		1 - For State Registrar	State of	of Marylan	d / Depa	artment of H	lealth ar Death	nd Mental H	lygien Reg. N		5 3	34001
Physici	ian	1. Decedent's Name (First, Midde Eve G. Harvey						2. Date of Month Sept	Death		Year	3. Time of Death 5:35A M
/Medic Examin		4a. Facility Name (If not institution Sunrise Assis	on, give street and nu	. 1	rick	4b. City, Town, or Freder			4	c. County o		3.33.1
Funeral Director		5. Social Security Number 101–03–5089	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of (Month, Nov.	Birth Day, Year 3, 19	912	Count	ace (State or Foreign ry) nsylvania
Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. Count MD Free	y derick		rederi						10	od. Inside City Limits
th with the 23a or 28a ist be notified	ai Director	10e. Street and Number 990 Waterfor	d Drive			10f. Zip Code	01		10g. C	itizen of W	nat Count	iry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any figury or other traumatic event, the Medical Exercities must be notified at Once.	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Formation Armed Formation In Transfer If Yes Green	2X No		Was Decedent of Hi f Yes, specify Cuba	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race Black Specify:	White, e	
d within 72 ho jiene. r than "natur ina Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	est grade completed) College ((Give life. I	dent's Usual Occupi kind of work done o DO NOT use retired maker	furing most o	f working		Kind of Bus		ustry
uld be filed Mental Hyg Irkad othe Itlc event,	To Be C	17. Father's Name (First, Middle Morris Glaze						s Name (First, Midd ah Greenb		n Surname)	
and 2 sho ealth and I m 27 is ma		19a. Informant's Name/Relation Stuart Harve			907	ng Address <i>(Street a</i> Motter Pl	ace I	or Rural Route Nur Frederick	nber, City , MD	or Town, S 2170	tate, Zip (Code)
Pages 1 tment of H tant: If Iter jury or oth	13 3	20a. Method of Disposition 1 ▼Burial 2 □ Cremation 4 □ Donation 5 □ Other (State Co	emetery, cren	sition (Name of natory or other plac Memorial		Date 0-3-2005		ocation - C		
permit Depar Impor any in		21. Signatore of Forgetal Bailty		>	7	Name and Address	lwy Fal	Nationa lls Churc	h, V			2
Physician and /Medical Examiner the private transit the private transit transi	dical Examiner	23a. Part . Exper the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, august . Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Deh Due to c.	ceused the death each line. ydration (or as a consequentia [or as a consequentia (or as a consequentia)	n uence of):	er the mode of dyin	g, such as ca	rdiac or respiratory	/ arrest,			Approximate Interval Between Onset and Death
the death certific by the attending p ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live	tcome of pregnal birth 2 Fetal nant at time of de lown	death 3	Ectopic pregnancy Other (specify)			-	23d. Date Mont		y Day Year
w requires that the de been signed by the s should be detached (by	Part II. Other significant condit CHF (Congest	tions contributing to d			nderlying cause give	n in Part I.		d tobacco		ute to the	e cause of death?
siclan: The law re certificate has be irector, page 2 sh	Completed	Atrial Fibri Pneumonia						24a. W au pe 1 🗆 Yes	topsy rformed?	pri de		sy findings available pletion of cause of
ding Phy After this funeral d	Certification; To Be	3 Suicide 6 Could	Hospital: 1 28a. Date (Montage Ingerting Ingertina Ingerting Ingertina Inge	of Injury oth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work M 1 🗀	at		sidence e how inju	ury occurred	j	
pital or A ours efter terel Direc filled in by	i Certif	4 Homicide deten	build	ing, etc. (Specify	·)	eet, factory, office	a data and n	City or 1	own, Stat	(0)		Route Number,
To the Hospital or Attand within 24 hours efter death To tha Funerel Director: completely filled in by the	Medical			pasis of examinat	ion and/or inv	restigation, in my op	inion, death	occurred at the tim	e, date an	s) and mani id place, an ate signed (d due to	the cause(s)
(1)		30. Name and address of person				Print)	4137		9,	/30/	\o_\	
Sta	ate_	Michael W. Co	r) 320F	Registrar's Signat	Ura	ımtown Pi	ke Fr	ederick,	MD 2	1702		
Registr		OCT 0 4	2005	we do	April	de						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		,	1 - For State Registrar	State of Maryland	l / Depa <i>Cer</i>	artment tificate	of H	ealth and l	Mental Hy	gien		34002
	Physici	20	Decedent's Name (First, Middle, Last)						2. Date of Do	eath Da	ay Year	3. Time of Death
	/Medic	al	JEAN ALICE HOUSTO				.	1000	Octob	er 3	, 2005	8:35 a ^M
4	Examin	er	4a. Facility Name (If not institution, give st					Location of Deat	n		County of De	
	Funeral		Collington Episcopa 5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under	1 Year	lville If Under 24 Hrs		rth .	Prince 9. Bi	George's thplace (State or Foreign country)
	Director		211-03-1326	M 201F 97	Yrs.	Months	Days	Hours Min.	March 9			nnsylvania
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation						10d. Inside City Limits
	Maryig f eho	ō										1 X Yes 2 □ No
	28a-	Funeral Director	Maryland Prince Ge 10e. Street and Number	orge s Mit	chell	10f. Zip				10g. C	itizen of What C	ountry?
	h with	al Di	10450 Lottsford Ro	ad		20	0716			II	S.A.	
	ems ?	ner		2. Was Decedent Ever in U.S Armed Forces?	. 13. V			spanic Origin? (S	Specify Yes or N		14. Race - Am Black, Wh	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 MNo If Yes, Give		I ☐ Yes 2					Specify:	
5-0036	72 hours after death with the Maryland neturel', or Items 23a or 28a-f ehow Itea Esa citiet must be mailfied at	q pa	3 Widowed 4 Divorced 15. Decedent's Education	Year or Dates:	16a. Deced	lant's Heus	LOccupa	tion		165 1	Wind of Busines	nite
15	n "ne	Completed	(Specify only highest grade	completed)	(Give	kind of wor DO NOT us	k done di e retired)	uring most of wo	rking	100. F	And of busines:	windustry
2121	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Manag	ger				Gr	ocery S	tore
pu	al Hy d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middle			
<u>ya</u>	Ment Marke Parke	ဂ္	James Hamilton					7417	a Mittn	-1-		
Maryland	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (Type	,				nd Number or Ru				
	1 and Health em 2		Louise Paul - Daug		2416 ace of Dispos	Lake	Aver	nue, Che	verly, l		land 20 location - City o	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28a-1 show any injury or other treumetic event, it a Mulfical Examination at the notified at ADE.		1 🕅 Burial 2 □ Cremation 3 🖼 Re `4 □ Donation 5 □ Other (Specify)	moval from State	metery, cren Mary ¹	natory or ot	her place	· 1	7/2005		,	New York
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B	Departiment of the control of the co		11410 N/a	2				more Av				
	W =20		23 . Pirt1. Enter the disease, or compli- slock, or heart failure. List only he	tions that caused the death.	Do not ente	er the mode	of dying	, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
H	Physician		Immigriate Cause (Final	Myocardial Int								Onset and Death 12 Hours
	/Medical Examiner		resulting in death)	Due to (or as a conseque								12 Hours
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	ted nsit	nlne	cause. Enter Underlying	Due to (or as a conseque	srice 01).							
Ď,	execunand and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):							
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9	certifica nding ph use as th	Completed by Physician/Medical	IF FEMALE:		-	_						-
Вох		lan/I	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnan1 ☐ Live birth 2 ☐ Fetal of	death 3	Ectopic pre					23d. Date of de Month	blivery Day Year
0.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of dea 9☐ Unknown	ath 5⊡	Other (spe	ecify)				WOLL	Day Cal
۵.	es that the death igned by the atte be detached for	/ Ph	Part II. Other significant conditions cont	ributing to death but not result	ting in the ur	nderlying ca	luse give	n in Part I.	23e. Did	tobacco	use contribute t	to the cause of death?
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000	2 9 %	lete	Dementia						24a. Was	an	24b. Were a	utopsy findings available
Re	The lay	omp	Dementia						auto perf	ormed?	prior to death?	completion of cause of
ita	icien: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Dea	70.0	2. No one)	o 1 □Ye	s 2 No
of Vital Records,	Physicien: this certific al director,	ToE	examiner? 1 ☐ Yes 2 No Ho	spital: 1 Inpatient 2 E	R/Outpatien	t 3 🗆 DO.	A Othe	r. 4 🛮 Nursing H	iome 5 Res	idence	6 ☐Other (Spi	ecify)
n O			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work		28d. Describe	how inju	iry occurred	
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Don Diese of lainer the		М		'es 2 □No	005 1	/04	- 411	
Οİ	or Alatter of Direction by	ertif	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	10, farm, stre	eet, factory,	, office		City or To	wn, Stat	nd Number or F 'e)	lural Route Number,
_	Hospitel A hours a Funerel I tely filled		29a. Certifier 1 X Certifying Physi	cian: To the best of my know	ledge, death	occurred a	at the time	e, date and place	, and due to the	cause(s	s) and manner a	s stated.
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examine one)	er: On the basis of examination and manner stated.	on and/or inv	estigation,	in my op	inion, death occu	urred at the time,	date an	d place, and du	e to the cause(s)
	To t To ti	Σ	29b. Signature and title of contifier	11/		29c.	License				ate signed (Mon	2"
			* WIMMED	11 110			D	47603			10/03/	05-
R	(10)		30. Name and address of person was con William F. DuBoyce,				Pos	d C+	p 216	D	i a W	land 20716
1	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signatu		^ TITE	KUd	u, sulte	= DZ10,	DOW	ie, Mary	/Lana 20/16
	O LL	er.	OCT 0.5.2005	E. L								

State of Maryland / Department of Health and Mental Hygiepen 34003 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JAMES A. HALL SEPTEMBER 21, 2005 11:25A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** XXM 2□F Months Yrs. Director 231 46 5623 66 AUG. 03, 1939 VIRĞINIA Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, it e Madical Examiner qualities at 10d. Inside City Limits XX Yes 2 No Directo MARYLAND | PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10g, Citizen of What Country? death with 3241 CHESTER GROVE ROAD Funeral 20774 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11TH MAINTENANCE SUPERVISOR D.C. GOVERNMENT filed permit. Pages 1 and 2 should be file Department of Health and Mental Hy; Important: If item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 JOHN T. HALL BEULAH JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSIE HALL / WIFE 3241 CHESTER GROVE RD. UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) ZION CHURCH CEMETERY 09/27/2005 KINSALE, VA 21. Signature of Funeral Service MARSHALL'S FUNERAL HOME OF MD/FISHER FUNERAL HOME lows 4308 SUITLAND RD. SUITLAND, MD/ OLDHAMS, VA 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) **Physician** PERI-RECTAL ABSCESS /Medical Due to (or as a consequence of) Examiner SEPTICEMIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ACUTE RENAL FAILURE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical RESPIRATORY FAILURE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) eu 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CROHN'S DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 Yes 1 ☐ Yes XX No 2 🗌 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: XIX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No Certification: To his 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending XX Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica 29b. Signature nd the of certif 29c. License number 29d. Date signed (Month, Day, Year) D60619 OCTOBER 04, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONNIE LE, M.D. 1500 FOREST GLEN RD. SILVER SPRING, MD 20910 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 5 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend, item 8 per inf 9851 1-5-06 vt.
State of Maryland / Department of Health and Mental Hygieten 0 5

		1 - For State Registrar	State of	viarylan	a / De p	artment of F rtificate of I	ieaith a Death	ina M		glene Reg. No.	105	34004
. Æ		1. Decedent's Name (First, Middle			-				2. Date of De	ath		3. Time of Death
Physici /Medi		Mary Elizabeth	Harrington	1					Month Septem	Day ber 2	Year 24, 200	5 12:55 a ^M
Exami		4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town, o	r Location of		•		County of Deat	n
		Washington Adv				Takoma I				Mo	ntgome	
Funeral		,	6. Sex 7. 1 M 2 X F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Big (Month, Da	3 ear)	Co.	nplace (State or Foreign untry)
Director		577-34-4249 Usual Residence of Decedent		78	113.				August -	18, 19	927 Was	shington, D
WOI		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
18 1-8	tor	Maryland Prince	e George's	Hv	attsvi	11e						1 X Yes 2 □ No
ir neam and wenter rygeries item 27 Ia marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be nutilled at	ire	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
23a (ai	3600 Manorwood	Drive			20782				U.S	.A.	
ter m	Funeral Director	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig an, Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	- 14	4. Race - Ame Black, White	
9		1 ☐ Never Married 2 ☐ Marri 3 🕅 Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 ☒ No	Specify:				Specify:	
al E	Completed by	15. Decedent	Year or Date	s:	l 16a Dece	dent's Usual Occup	ation				WI	nite
Spedic	ojet	(Specify only highes	t grade completed)		(Give	kind of work done of DO NOT use retired	during most	of workin	g	160. Kind	d of Business/I	ndustry
In A	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	!	ness Owne				Priv	ate	
/ent,	0	17. Father's Name (First, Middle, I	Last)			WILCON OWING		r's Name	(First, Middle,			
tic e	To B	James Phelps					Vero	nica	Carr			
апша		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ing Address (Street	and Number	r or Rurai	Route Number	er, City or	Town, State, Z	ip Code)
any injury or other trau		Noreen Burns -	Daughter		4610	Barbara	Drive	. Bu	ltsvill	e. M	arvland	20705
r oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Pamoual from Sta		lace of Dispo	osition (Name of matory or other place		D	ate	20c. Loc	ation - City or	Town, State
ury o		'4 □ Donation 5 □ Other (Sc	pecify)	Gat		Heaven Ceme		9/27	/2005	Silv	ver Spr	ing, Marylan
ny inj		21. Signature of Funeral Service I	icensee			2. Name and Addres		Gas	ch's Fu	inera	1 Home,	P.A.
e 0		Hen K. UC	lelly								le, Mar	yland 2078
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death 1 line.	h. Do not en	ter the mode of dyin	g, such as c	ardiac or	respiratory ar	rest,		Approximate Interval Between
ian		Immediate Cause (Final disea e or condition resulting in death)	_a Myocar	dial 1	Infarc	tion						Onset and Death
ical ner		resulting in dealin)		as a conseq								
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al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):					_		
the burial-transit	dicai											
as II												
TOT USB as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth	me of pregna		□Ectopic pregnancy				23	d. Date of deli	*
2	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of d		Other (specify)					Month	Day Year
delar ed	by Physician/Me	9 Unknown							00 5:			
3	by	Part II. Other significant condition Congestive Hear		i but not resi	uiting in the t	irideriying cause giv	en in Part I.					the cause of death?
sponia	eted	congestive hear	c rarrure						, , ,	res 2 🗆		bably 4 Munknown
	Completed	Peripheral Vasc	ular Disea	se					24a. Was autop	sv	prior to c	topsy findings available ompletion of cause of
r, page 2 :									1 Yes	rmed? 2 X No	death?	2 No
recto	Be	25. Was case referred to medical examiner?	Hospital:			nt 3 DOA Oth	-		(Check only o		-	
3	.: To	1 Yes 2 XNo 27. Manner of Death	1 LX Inpa		ER/Outpatie	III JUDON	4 🗆 1401	-	ne 5 ☐ Resid 8d. Describe h		Other (Spec	ify)
funeral director,	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	Injury	Worl	k?ື Yes 2⊡N			ov injury	occurred	
y the	fica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place of	Injury - At ho	ome, farm, st	reet, factory, office		2	8f. Location (5	Street and	Number or Ru	ral Route Number,
l ui þ	Certification;	4 Homicide	building,	etc. (Specify	Y)				City or Tov	m, State)		
completely filled in by the	edical (29a. Certifier 1 X Certifyin (Check only one)	g Physician: To the be Examiner: On the basis and manner	s of examina	wledge, deat tion and/or in	th occurred at the tin	ne, date and pinion, death	l place, a h occurre	nd due to the d at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
omple	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Date	signed (Month	, Day, Year)
_		1 Jan	a. a.	~ ·	MD	D50	590			Sent	ombar 2	2005
;)		30. Name and address of person	who completed cause of	of death (Item	n 23a) (Tvpe					Dept	CIUDET 2	.0, 2003
5/		Jonathan A. Cal					Suite	400	Takom	a Par	k. Mar	yland 20912
	ate	31. Date filed (Month, Day, Year)	82. Regi	strar's Signa	iture			,			-A-9 1164 L	,
Regist	rar	OCT 0 5 20	05 Kleen	, K	Apos							
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State of Maryland / Department of Health and Mental Hygiene 15 For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Andrew W. Huntress, Jr. 2:20pM 2005 Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 5 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-34-0964 ^{Year)} 1929 75 Director Wash. DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itams 23a or 28a-f show Examiner must be nutified at Md. Montgomery Rockville 1 XYes 2 No Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1952-54 1 ☐ Yes 2X No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NASA Goddard othar than Elementary/Secondary (0-12) College (1-4or 5+) Engineer Space Flight Center 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I Andrew Whitehouse Huntress Anna Geiman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7605- Sebago Rd., Diana Deem -Daughter Bethesda, Md. Health itam 27 I 20b. Place of Disposition (Name of cametery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Woodlawn Cemetery 10/8/2005 olace) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. S. Berwick, Maine * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Hysong Co., Inc. 6510 16th St., 23a. Part1. Enter the disease, or com shock, or heart failure. List only S+ NW Wardiac or respiratory arrest, Wash DC the mode of dying, such as cardiac Approximate nterval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying death certificate be executed burial-tran that initiated events resulting in death) Last ng physician a as the burial Box 68760. Physician/Medical use IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 2 Fetal death Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: Other: 4 Invursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **Division** Hospital or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident ractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Dirac 4 Homicide within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh- 9701-Veirs Dr., Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 5 2005

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 05 34006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Sepkahers, 2005 3:45 Am Shirley

	Exami	ner	4a Fecility Neme (If not institution, gi	ve street end number)	1 -			4b. City, Town,	or Location of De			
			(romwell Nu	Using by	feml		•	Park			altimo	
	Funeral Director			Sex 7. Age (In yrs. lest bir. 75	thday) If Unde Months	r 1 Year Days		Min. 8. Date of E Sept.	T5, 1930	9. Birthplace Country) West	(State or Foreig
	P.	•	Usuel Residence of Decedent									
	aryler and an aryler	_	10a. State 10b. County		Oc. City, Town							Inside City Limits
	Ba-f.	Director	Maryland Balti	more		Pa	rkvi	lle				1 ☐ Yes 2 🖾 No
	子 2g 計	Sire	10e. Street end Number			10f. Zij	Code			10g. Citizen of	Whet Country?	
	ath with the Marylen 23a or 28a-f show unt be notified at		8710 Emge F	Rd.				21234		U	.S.A.	
	Hems Hems	Funerai	11. Marital Status	12. Was Decedent Everaged Forces?	er in U,S.	13. Was Dece	dent of I	Hispenic Origin?	(Specify Yes or Nuerto Rican, etc.)	lo- 14. Rac	e - American I	ndian,
020	72 hours after death with the Marylend natural', or Nema 23a or 28a-f show dical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖄 No If Yes, Give Year or Dates:				Specify:		Specif	. ,	2
5	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16e.	Decedent's Usu (Give kind of wo life. DO NOT u	al Occu	petion during most of	workina	16b. Kind of B	usiness/Indust	гу
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פ	othe file	Be	17. Father's Neme (First, Middle, Last)				18. Mother's I	Name (First, Middl	e, Maiden Suman	7e)	
<u>a</u>	Alenta Alenta rked tic e	To E	James McElroy						Bula Mo	rre		
al	and had	•	19a, Informant's Name/Relationship		19b.	Mailing Address	s (Street	and Number or	Rurel Route Num	ber, City or Town,	Stete, Zip Cod	de)
Σ	and 2 alth a 27 is	ij	Debbie Calleri/da	ughter	40	9 Cherry	/ 0a	k Ct.	Taneyto	wn, MD 2	1787	
ore	ges 1 an it of Heal If Rem 2 or other		20a. Method of Disposition	7p	20b. Place of cemeter	Disposition (Nar	me of other pla	ce)	Date	20c. Location -	City or Town,	State
<u>Ĕ</u>			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	JHemovai from State		's Cemet			9/28/05	Ladies	burg, M	ID
Baltimore,	pemit. Pe Depertmar Important: any Injury pnce.		21. Signature of Funeral Service Lice	() × 6.7	Her	22. Name ar	nd Addre	in St.	artzler	Funeral I	Home 21798	
		П	23a. Part1. Enter the disease, or com	plications that caused th	e deeth. Don	1						proximate
19	Physician		shock, or heart failure. List only	one cause on each line.			,	3.	,		Inte	erval Between set and Death
)	/Medical		Immediate Cause (Final	(adi	ar	Arrhy	the	200				
	Examiner		disease or condition resulting in death)	a		onsequence of):	0111	· · ·			1	
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	cuted od rensi	Ē	Sequentially list conditions	b. ————————————————————————————————————	e to (or as a c	onsequence of):						
Õ	an ar	Ë	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events								!	
376	ysici he bu	Ca	that initieted events resulting in death) Last	C	e to (or as e co	onsequence of):						
P.O. Box 68760,	entifica ing ph eas t	Physiclan/Medical Examiner	L	4							İ	
8	ath ce ttend or us	lan/	_	d								
_ _	e da: tha a had f	/sic	Part II. Other significant conditions of	ontributing to death but n	ot resulting in	the underlying c	ause giv	en in Part I.	23b. Dic	tobacco use co	ntribute to the	cause of death
	that the daath certificate be axecuted the by the attending physician and detechad for use as the bunat-trensit	by Ph							1	Yes 2□No	3 Probably	4 Unknow
Records,	uiras n sign	۵ ۵							24a. We	s an autopsy	24b. Were a	utopsy findings
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ā	n: Ti ficati or, pe		25. Was case referred to medical					00 51 /-		Yes 2 1 No	1	s 2 No
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Division of Vital	tending leath. tor: Afte the fune	catior	1			М		k? Yes 2 □ No				
	s after of it Direct ad in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, fan Specify)	m, street, factory	, office		28f. Location City or To	(Street and Numb wn, State)	er or Rural Ro	ute Number,
	To the Hospital or Attending Physician: The law requiras within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, pege 2 should be	edlcai (29a. Certifier (Check only one)	ysician: To the best of m niner: On the basis of ex and manner stated	amination and	death occurred a /or investigation,	at the tin	ne, date and pla pinion, death oc	ice, and due to the curred at the time	cause(s) and ma date and place, a	nner as stated and due to the	cause(s)
. 1	withii To th	ž	29b. Signature and title of certifier			29c	. Licens	e number		29d. Date signed	(Month, Day,	Year)
	WIL		> Gilling	guenn		1	200	19855		Septend	n 28.	2005
	1	1	30. Name end see ss of person who	completed cause of death	h (Item 23e) (1	Type, Print)	Sine	lin Go	omp	Septembre 2/2:	1	
		_	560/ Roch	Ruler	1 /31	vd,	30	from	- mo	2/2:	39	

State

Registrar

31. Dete filed (Month, Day, Year)

SEP 3 0 2005

32. Regidrar's Signature

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Sept. 24 2005 9:00P Richard B. Holland /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 XM 2 ☐ F 28, 57 Sept. 1947 Maryland Director 578**–**60**–**6217 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Lothian Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20711 United States 5430 Sands Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or items 23siry or other traumatic event, the Medical Examinat rivial. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 9th Private Custodian 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Julia Reid Roland Holland ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roland Holland/Brother 6117 Hilmar Drive, Forestville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 3, 2005 Sunderland, Md. Oct. * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope Cemetery Pope 5538 Pope Funeral Homes 5538 Marlboro Pike Forestville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease of complications that caused the death, shock, or heart failure. Use one cause on each line. Immediate Cause (Final disease or condition resulting in death) Neumonia Priysician /Medical Due to (or as a consequence of): TRANS Examiner in y serie Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed 51 that initiated events resulting in death) Last Due to (or a a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death Year Month Day in the past 12 months? 5 Other (specify) signed by the ald be detached for □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Pes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No 24a. Was an has autopsy 25 Rio 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 ER/Outpatient 3 DOA P 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Douth after death. i Director: After t Certification: 1 Accident Injury 5 Pending 1 🗌 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Pertifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the o 29a. Certifier on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 2005 Completed cau of death (Item 23a) (Type, Pont) Kesni 10 31. Date filod (Month, Day, Year) Registrar's Signature State OCT 0 4 2005 Registrar

			1- For State of M	aryland / Depa <i>Ce</i>	artment of Health and rtificate of Death	Mental Hygier	
	Physici /Medi			FFRIES		2. Date of Death	3. Time of Death 10, 2005 1604 P.M.
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	Funeral Director		060-38-7167 1□ M 2⊠ F Usual Residence of Decedent	58 Yrs.	Months Days Hours Min	(Month, Day, Yea	9. Birthplace (State or Foreign Country) 1947 ITALY
	ne Marylan 8a-f ehow	Director	10a. State 10b. County MARYLAND WASHINGTON	10c. City, Town or Lo	BOONSBORO		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	eath with the ne 23s or 2	Funeral Dire	10e. Street and Number 20717 EL RANCHO ROAD 11. Marital Status 12. Was Decedent	Ever in II S 12	10f. Zip Code 21713		U.S.A.
036	ours after death with the Marylar rel', or Items 23a or 28a-f ehow Exa old of rous to	þ	1 Never Married 2 Married I yes 2 W If yes, 2 ive year or Dates:	No I	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specity: WHITE
9500-5121	I within 72 hours after death with the Maryland liene. r then "naturel", or Items 23e or 28e-f ehow the Medicel Exaninar rouel be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	Kind of Business/Industry
and Z	be filed htal Hygi od other event, I	To Be Co	12 17. Father's Name (First, Middle, Last) LUIGI BRAIDOTTI		ANGUAGE SPECIALIS 18. Mother's Nat ELSA TO	me (First, Middle, Maide	DERAL GOVERNMENT on Sumame)
, mary	nd 2 shoulth and 27 is my	-	19a. Informant's Name/Relationship (Type, Print) WARREN D. JEFFRIES/SPOUSE		ng Address (Street and Number or Re EL RANCHO ROAD,	ural Route Number, City	
cimore,	permit. Pages 1 a Department of Hes Important: if item eny injury or othe		20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date 20c. I 12/05 SMI	Location - City or Town, State THSBURG, MARYLAND
g D	Depar Impor ony ir		21. Signature of Funer / Sarvice Lifense Paul 23a. Part Lefter the disease, or complications that cause shock or head failure. List copy one source or each life to the copy one source or each life.	M. Dean BA	AST FUNERAL HOME	Boonsboro,	Maryland 21713 Approximate
eg) Eg	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence of):	un cour		Interval Between Onset and Death
te.	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. En all in ething Cause (Disease or injury	a consequence of):			
9/00,	cate be executed physician and the burial-transit	dicai Examin	that initiated events	a consequence of):			
20 X 02	ith certificate tending physi or use as the l	Φ.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy		23d. Date of delivery
5	uires that the death certifi signed by the attending I d be detached for use as	Physician/M	1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death b		Other (specify)	23a Did tohacco	Month Day Year use contribute to the cause of death?
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אוומו אב	an: The la tificate has tor, page 2	e C	25. Was case referred to medical		26 Place of Day	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
5 5	ng Physici fter this cer ineral direc	on; To B	examiner? 1 Yes No Hospital Inpatite 27. Manner of Death	ry 28b. Time of	t 3 DOA Cther: 4 Nursing H	ome 5 Residence 28d. Describe how inju	
	I or Attendi after death. Director: A in by the fu	Certification	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inj	ury - At home, farm, stre c. (Specify)	M 1 Yes 2 No	28f. Location (Street al City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attending Physician: The law requir within 24 hours attendeath. To the Funeral Director, After this certificate has been si completely filled in by the funeral director, page 2 should it.	Medical Co	29a Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis o and manner sta	i examination and/or inv	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	i) and manner as stated. d place, and due to the cause(s)
	cz	Ň	29b. Signature and title of certifier	la MI	29c. License number	3 (O	ate signed (Month, Day, Year)
	20		30. Name and address of person who completed cause of defined that the same and the	, 1130	OPAL CT.	Hagen	stown, m) 21740
	Sta Registr		OCT 1 2 2005	ar Signature	rete		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fb 9848 10-20-05 vt
State of Maryland / Department of Health and Mental Hygiegen 0 5 34009 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCTOBER Day 3, 2005 **Physician** ALBERTA ROSE JONES 9:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2090 SMITH POINT ROAD NANJEMOY CHARLES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 5. 95786-22×18546 **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Director 81 - 22 MAR. 18, 1924 WASH , D . C Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MARYLAND CHARLES NANJEMOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 2090 SMITH POINT ROAD 20662 238 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: ltems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: β Specify: 3€XWidowed 4 □ Divorced WHITE "naturel', Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within in Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES REPRESENTATIVE WOODWARD & LOTHROP 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TRAVIS LEWIS LEAPLEY NORA BUTTS 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK LEAPLEY-NEPHEW 2507 LAZY ACRES RD., CLINTON, MARYLAND 20735 20b. Place of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) ☐ ☐ ☐ OLD DURHAM EPISCOPAL CEM. 10-17-05 IRONSIDES, MD 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final MCE ECOPHARY C Physician OF disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 04 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner be executed igned by the attending physicien and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 2 KN0 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ٩ 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifie (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01 Koush Matt 0

12

State

Registrar

31. Date filed (Month, Day, Year)

2005 0

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jo Year **Physician** eptember 2005 Gloria Amelia Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 🔀 F Yrs. Director 218-38-9169 68 August 3 1937 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov the Madical Examiner must be notified at 1 XYes 2 No Director Prince George's Glenn Da1e 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20769 U.S.A. , or items 23a 11000 Brookland Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Private HomeMaker llth or other traumatic event, permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if tiem 27 is marked oth ery injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifton E. Jackson Gladys B. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9010 Breezewood Terr. # 201 Greenbelt, Maryland 20770 D. Hill/Daughter Gloria 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/8/05 GlennDale, Maryland Church Cemetery 21. Signature of Euneral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 mor Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ After this certificate has been sign funeral director, page 2 should be 1 Tes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director:, completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Ne of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ad ple ed cause of death (Item 23a) (Type, Print)

State Registrar ng MD 8118 Good Hope Road Lanham, Maryland

Jeffrey J. Hang MD

2005

31. Date filed (Month, Day, Year)

OCT 0 4

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ate of Maryland / Department of Health and Menta	Hygienen	05	31.0
Certificate of Death	70 20	UJ	040
Cenncale Or Deam	Dog No		

Physician
/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23s or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notifiled at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospitel or Atlending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atlending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CHAMPION JACK JOHNSON

1. Decedent's Name (First, Middle, Last)			Timouto c	of Death	2. Date of D	Rag. No	o.	3. Time of Dea
					Month	Da		ar
Champion Jack			1 0 T		_ 1		26. 200 County of De	
a. Facility Name (If not institution, give s				n, or Location of De		40	•	
St. Mary's H				Leonardto ar If Under 24 H				Mary's
i. Social Security Number 6. Sex	. Age (in: KM 2□F	yrs. last birthday	Months Da		n. (Month, D	ay, Year		Birthplace (State or Fo Country)
577-03-5309		91 ****			Jan. 2	9, 1	.914 N	orth Carol
Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation					10d. Inside City Li
V				Chantina				1 XYes 2
Maryland St. Ma	ary s		10f. Zip Cod	<u>Chaptico</u> _®		10g. C	itizen of What	Country?
36036 Bay Drive	(D O Pov	271)		20621			Unite	d States
	12. Was Decedent Ever		. Was Decedent			0-		merican Indian,
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo		If Yes, specify C	of Hispanic Origin? Juban, Mexican, Pu	erto Rican, etc.)		Black, W	hite, etc. African
3 XVidowed 4 Divorced	If Yes, Give Year or Dates:		1☐ Yes 2☐X	No Specify:			Specific	American
15. Decedent's Educ		16a, Dece	edent's Usual Oc	cupation		16b. h	Kind of Busine	
(Specify only highest grade	ocompleted)	(Giv	e kind of work do DO NOT use re	ne during most of v tired)	rorking			,
Elementary/Secondary (0-12)	College (1-4or 5+)	Ног	avy Faui	pment Med	hanic		Dr	ivate
17. Father's Name (First, Middle, Last)		nea	ivy Equi		ame (First, Middle	, Maidei		IVALE
James Edward	Iohnson						Glass	
		10h Mail	line Address (Cts	eet and Number or				200
19a. Informant's Name/Relationship (Typ. Annie V. Wincheste								ptico, MD
			osition (Name of		Date			or Town, State
20a. Method of Disposition 1 👿 Burial 2 □ Cremation 3 □ Re		cemetery, cre	ematory or other	place)	Date	200. L	ocation - City	or rown, state
4 ☐ Donation 5 ☐ Other (Specify)	M	aryland	Nat. Me	m. Park l	0/4/2005		Laure	1, MD
21. Signature of Funeral Service License	F- (+-	TT 2	22. Name and Ad	dress of Facility Benning F	Stewart			
John J	Langer I	-					, DO	Approximate
23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.							Interval Between
Immediate Cause (Final disease or condition	PROCTA	TE CA	MLER	E WET	ASTASI	2		MUNTA
resulting in death)	Due to (or as a cor		,,,					1.07.17
Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence of):						
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
that initiated events c resulting in death) Last	Due to (or as a cor	nsequence of):						
_ d	ł							
IF FEMALE:	3c. If yes, outcome of pr	ecnancy					Cod Date of	dolives
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 🗌	Fetal death 3	□Ectopic pregna				23d. Date of o Month	оенvery Day Year
1 ☐ Yes 2 ☐ No	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				
9 🗆 Unknown					00- D:-		use contribute	a to the source of death
	ntributing to death but no	t resulting in the	underlying cause	given in Part I.				to the cause of death
9 🗆 Unknown	ntributing to death but no	t resulting in the	underlying cause	given in Part I.		tobacco Yes 2		Probably 4 Donkr
9 🗆 Unknown	ntributing to death but no	t resulting in the	underlying cause	given in Part I.		Yes 2	No 3	Probably 4 Donkr
9 🗆 Unknown	ntributing to death but no	t resulting in the	underlying cause	given in Part I.	1 - 24a. Was	Yes 2 s an opsy ormed?	24b. Were prior t	autopsy findings avaito completion of cause
9 ☐ Unknown Part II. Dther significant conditions con	ntributing to death but no	t resulting in the	underlying cause		24a. Was auto perf	Yes 2 s an opsy ormed?	24b. Were prior t	autopsy findings avaito completion of cause
9 ☐ Unknown Part II. Dther significant conditions con 25. Was case referred to medical		t resulting in the		26. Place of D	24a. Was	Yes 2 s an opsy ormed?	24b. Were prior t	autopsy findings avaito completion of cause
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9 Unknown Part II. Dther significant conditions con 25. Was case referred to medical examiner? 1	lospital: 1 ☑ ffipatient 28a. Date of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (St.)	2 EP/Outpatie ar) 28b. Time Injury At home, farm, s	ont 3 DOA of 28c. I M treet, factory, offi	26. Place of DOTHER: 4 Nursing Nury at Nork? Yes 2 No ce	24a. War autoper 1 yes leath (Check only 28d. Describe 28f. Location City or Touce, and due to the	Yes 2 s an ppsy ormed? 2 No one) idence how inju (Street a wm, State e cause(s, date an	24b. Were prior to death of the control of the cont	Probably 4 Onkr autopsy findings avaito completion of causer res 2 No specify) Rural Route Number, as stated.
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANNA RUTH JACQUETTE OCTOBER 1 2005 ear 01:00 A M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth SEPT 22,1931 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country)
 MD 220-28-0878 1 M 2 XF 74 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other then "natural", or items 23a or 28a-f show ary or other traumatic event, I'm Medical Exertings by profitied at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD KENT ROCK HALL Director 1 ☐ Yes 2 ☑ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6199 ROCK HALL ROAD 21661 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM MARTIN WAGNER FLORENCE CORNELIUS 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRED JACQUETTE/HUSBAND 6199 ROCK HALL ROAD, ROCK HALL, MD 21661 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or WESLEY CHAPEL CEMETERY OCT. 3, 2005 ROCK HALL, MD ¹ 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Eaching EIN & NEWNAM FUNERAL HOME, P.A. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician An teriosclastic Cardioroscula 10 years /Medical Due to (or as a consequence of) Examiner Soque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 poinths?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ eg kiring divertingcolorism S de no No 3 Probably Completed 1 🗌 Yes 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 2 Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) in by the funeral 27. Menner of Death Medical Certification: 28b. Time of after death. 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral [To tha Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D17036 - Mel. 120) 16000, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12-5

State Registrar Washington

32. Register's Signature

516

mD

0 4 2005

K. Ro 55,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieze 0 5 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer eptember 2) **Physician** 2003 04.000 mes /Medical County of Death 4b. City, Town, or Location of Death 4c. Facility Name (If not institution, give street and number) **Examiner** 101mape 77a If Under 24 Hrs. 9. Birthplece (State or Foreign 8. Date of Birth (Month, Day, In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 06-06-1957 LANCASTER, PA. 179-48-6181 48 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show r then "naturel", or items 23a or 28a-f shov the Middled Examinary ust be notified at 1 ☐ Yes X☐ No Completed by Funeral Director **FELTON** DE KENT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19943 USA ROAD 122 PRATTS BRANCH 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or item any injury or other treumatic avant, the Medical Experimental Department of the process. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 👿 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CITY OF DOVER DOVER CITY POLICE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOYCE W. ARTHUR RENE THOMAS KURTZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KAREN E. WEAVER KURTZ (WIFE) 122 PRATTS BRANCH ROAD, FELTON, DELAWARE 19943 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition FELLOWS CEMETERY
CAMDEN 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) ODĎ 09-26-2005 CAMDEN, DELAWARE 21. Signature of Funeral Service Licensee TRADER FUNERAL HOME INC. Bomes E. 12 LOTUS ST., DOVER, DELAWARE 19901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 Mouths **Physician** nultiple /Medical Due to (or as *consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 X No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy After this certificate has performe 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 7 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending Natural 1 Yes 2 No after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES -000 SEPTEMBER 22, 2005 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MO 21287 NORTH WOLFE 600 KRISHNASWAMY 32, Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2 2005 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar State of Maryland / Department of Health and Mental Hygiere 15 per Dr., G851 entiricate / Gelbh Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Michael Edward Kangas A^{M} 8:05 October 0 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 45660 Swanfall Way California St. Mary's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 10XM 2□ F Yrs. 45 Nov. 19,1959 Illinois 216-80-8469 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 ie marked other than "natural", or Iteme 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 Yes 2 No St. Mary's Maryland California Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? White Oak CT. 20619 44691 Apt. 507 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 ☑ No Specify. Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Contract Management Specialist US Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Oliver R. Kangas Catherine M. Laznicka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45660 Swanfall Way California MD. 20619 Oliver R. Kangas / Father other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 4 Donation 5 ☐ Other (Specify) Michael Cemetery 10/15/2005 Ridge, Maryland 22. Name and Address of Facility Brinsfield Funeral Home P.A. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Rd. Leonardtown, MD 20650 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Betv Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Examiner physicien and the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 2 No 1□ Yes 86 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ဥ 1 Yes 2 No 3 DOA uneral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Matural 5 Pending 1 Tes 2 No М investigation 2 Accident tilled in by the Director 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Examiner **Funeral** Director the Maryland 72 hours after Baltimore, Maryland 21215-0036 and Mental Hygiene. Pages 1 and 2 should be filment of Health and Mental Hant: If item 27 is marked ot permit Page Department of Important: If any injury or once. Physician /Medical Examiner death certificate be executed Box 68760 P.O. The law requires that the Records, of Vital Attending Physicien: Medical Certification: Division death. ö Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely til To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier October 13,2005 of death (Item 23a) (Type, Frint) 48 30. Name and address of erson who completed ca 24035 Three Notch Rd. Hollywood, MD. 20636 Dr. Patrick Jarboe, M.D. 31. Date filed (Month, Day, Year) 32 Registar's Signature State **JOCT 13** 2005

Registrar DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Margaret Lucille Keyes /Medical October 2005 5:30 a. 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1024 River Point Road Cambridge: Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Days Hours Director 214-07-7747 88 Yrs. 10, 1917 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location or Items 23a or 28a-f ahov the Medical Examiner must be nutified at 10d. Inside City Limits Dorchester Director Cambridge 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1024 River Point Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after copartment of Health and Mental Hygiene. Important: if tiem 27 ia marked other than "natural", or Iten any injury or other traumatic event, the Mental once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: 3° Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) line worker 8 electronics 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Hamilton Thomas ပ Mamie Mowbray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Keyes 612 Twin Point Cove Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spedden Seward Cem. 10/6/05 Cambridge, MD 21. Signal expf Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD um 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Non Small Onset and Death **Physician** 4months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Caquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last physician at s the burial-to Due to (or as a consequence of): Box 68760. Physiclan/Medical 98 IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) Month Day Year P.0. Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1

Yes 2

No 3

Probably 4

Unknown been page 2 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed: 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification; 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signal e and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 03988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David H. Smith, M.D. 29466 Pintail Dr., Easton, MD 21601 31. Date filed (Month, Day, Year) OCT 05 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** lorma 2:45PM /Medical 0 200 S Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death ester River Kent TOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 ▼F 218-20-8607 78 Director Yrs. JUNE16,1927 MDUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural; or itema 23a or 28a-f show It e Modical Examiner must be notified at 10d. Inside City Limits Funeral Director MD KENT CHESTERTOWN 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 97 CLIPPER WAY 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ৺ Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NORMAN DILL ္ပ MAUDE STAUBE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMAN PORTER/SON 6044 NORTH MAIN STREET, ROCK HALL, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State WESLEY CHAPEL * 4 ☐ Donation 5 ☐ Other (Specify) OCT.8,2005 ROCK HALL, MD 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer ung mos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy 2 🗆 No 1 Yes 2 No 1 Yes or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of . Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical-Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D58824 (4) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vonaher 1196 Main MI Galana. 31. Date filed (Month, Day, Year) 32. Registras Signature State Registrar 2005

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Baltimore,	permit. Pages 1 and Department of Health Important: if item 21 eny injury or other t		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	Removal from State	cemete	ry, crema	tion (Name of atory or other plac			ate		ocation - City o		1 1
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	ie deat the att hed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 🗆	Other (specify) _							
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isio	death ctor: / y the f	licat	2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of In	jury - At home, f	d 9:55 arm, stre	et, factory, office		-	20f Location	(Ctront o	and Alumbas as 6	Pural Pouta Nu	mber,
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	To the Hospital or Attenwithin 24 hours after deatle To the Funerel Directors completely filled in by the	Medical Certification:	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the besi niner: On the basis and manner s	of examination a	ge, death .nd/or inv	occurred at the ti estigation, in my	me, date a opinion, de	and place, eath occurr	and due to the ed at the time,	cause(s	s) and man er and place, and di	as stated. ue to the cause	(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	se number	,		29d. D	ate signed (Mo	nth, Day, Year)	
	SAE		I hij his,	m.D			0	.с.м.	Ε.		Octo	ober 12	, 2005	
	53		30. Name and address of person who		death (Item 23a) (Type, F	Penn Str	eet	Re1+	imore	Mars	zland 21	1201	
				N i D					rurt.		ر عمد	,		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	3 2005	ar's Signature	#	ford	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115

			1 - For State Registrar	State of Maryla		artment of F rtificate of I			a. No.	34018
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Louise M.	Lane				2. Date of Death Month October	Day Yeer 13, 20	3. Time of Death 12:00 pm
	Examin		4a. Fecility Name (If not institution, give stree Caroline Nursin 5. Social Security Number 6. Sex	eet and number) ag Home 7. Age (In yr	s. last birthday)		nton If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of De Carol	ine irthplece (State or Foreign Country)
影	Director		219-80-0705 Usual Residence of Decedent 10a. State 10b. County		Yrs. City, Town or Lo			Mar. 21	,1911 M	aryland 10d. Inside City Limits
	Jeath with the Marylan ns 23s or 28s-f show Table to the lifted st	Director	MD Carolin 10e. Street and Number		Pres			10	g. Citizen of What (1 Yes 2 100
	th with		4590 Newton Roa	ıd			21655		nited S	
036	ours after or rat', or Iter	by Funeral	11. Marital Status 12. 1 Never Married 2 Married 3 Note of American 12.	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:		14. Race - An Black, Wh Specify: W	nite, etc.
Maryland 21215-0036	be filed within 72 hours tal Hygiene d other than "natural" avent, Ins Midical Ex	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	conpleted) College (1-4or 5+)		dent's Usual Occup kind of work done of DO NOT use retired Ool Tead		king	Sb. Kind of Busines Educati	
land z	a d a	To Be Co	17. Father's Name (First, Middle, Last) Bannister Slocu				18. Mother's Nam	ne (First, Middle, Ma	aiden Sumame)	
	and 2 should I eatth and Men n 27 is marks er trsumstic		19a. Informant's Name/Relationship (Туре, Jack R. Lane (S					Presto		
Baltimore,	- I 5 5		20a. Method of Disposition 1 3 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	Junior C	rder Cem	. 10/	17/05 F		Maryland
Balt	permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service Licensee	skew						Home, P.A. , MD 21632
	Physician /Medical		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one disease or condition resulting in death)	tions that caused the decause on each line. Due to (or as a cons	13he		1	or respiratory arres men Fia	t,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to interrediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons						
,09	be executed sician and burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
68760,	tificate t g physi as the b	edlcai	d							
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23c. 23c. in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
1	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions contrib	buting to death but not r Ribrill	, ,	nderlying cause givi	en in Part I.	23e. Did toba 1 ☐ Yes		to the cause of death? Probably 4 □Unknown
Vital Records,		Completed		<i>V</i>				24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of
VII	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	pital:		Oth	00	th (Check only one)		
O	g Physie this seral di	n: To		1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	IT 3 DOA	4) Nursing H	ome 5 Residen 28d. Describe how		ecity)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	M 1 🗆	Yes 2 □ No	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dii completely filled in	edical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examinet	ian: To the best of my k r: On the basis of exami and manner stated.	nowledge, death	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	AKI.	40	29c. License	4753		I. Date signed (Mor	
		Ī	30. Name and address of person who comp Wa fix Zaki, MD	pleted cause of death (III 920 M	tem 23a) (Type. avket s			2162	, , ,	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 7 201	32. Registrar's Sig	nature	Speeds				

		ľ	1 - State Registrar	State of Marylar	nd / Depart <i>Certi</i>	ment of H	lealth and Death		gien 2 0 0 5	34019
	Physici /Medic	al	to Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give si	1 1 1	OFORC	h City Town o	170 N	2. Date of Dea Month	ath Day Yea	5 1/20"
	Examin Funeral Director	er	5. Social Security Number 6. Sex 216-70-5624	PCE AT / T. Age (In yrs. 45	AKE [ast birthday]	f Under 1 Year Nonths Days	If Under 24 Hrs Hours Min.	4	Wicon	irthplace (State or Foreign Country) RLESTON, WV.
	Maryland I-f ahow	tor	Usual Residence of Decedent 10a, State 10b, County MD WICOMIO		SALISBU					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?
	eath v	Funeral	2446 ST. LUKES ROAL) 2. Was Decedent Ever in U	.S. 13. Wa		21804 ispanic Origin? (5	Specify Yes or No-	USA 14. Race - An	nencan Indian,
920	hours after death with the Maryland tural; or Iteme 23a or 28a-1 ahow al Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:		es, specify Cuba Yes 2√∑ No	n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, Wh	
Maryland 21215-003	in 72 n "na" r	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1.2		(Give kin life. DO	t's Usual Occup d of work done o NDT use retired LSTERED	during most of wo I)	rking	16b. Kind of Busines COUNTY GO	
nd 2	al Hygiene. I other than	Be Co	17. Father's Name (First, Middle, Last)		KEG.	LUIERED		me (First, Middle,	Maiden Surname)	A INIMITEM I
<u> </u>	Men Men arke	2	DELBERT FRANKLIN H. 19a, Informant's Name/Relationship (Typ)		10h Mailing	Address (Strant		ANN CONLE	EY r, City or Town, State,	Zin Code)
	12 s h ar 7 is trau		TINA MOORE - SISTER						, MARYLAN	, ,
Itimore,	of t		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	Place of Dispositi cemetery, cremated MICO MI	ory or other plac	1	Date 4-2005 S	20c. Location - City of	
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service License		22. N	ame and Addres	ss of FacilityBOT	UNDS FUNE	ERAL HOME, BURY, MARYL	INC.
	Physician		23a. Part 1 Enter the disease, or complete shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the sale cause on each line. MRTATA				c or respiratory ari		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec		OKI M.	> <u> </u>	77012		TYBAR
1	香	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):					
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical Exa	that initiated events c. resulting in death) Last	Due to (or as a consec	uence of):					
× 68	ertificat ling phy e as th	Medi	IF FEMALE:							
O. Box	at the death certifica by the attending ph tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	Ideath 3□Ed	topic pregnancy ther (specify)			23d. Date of d Month	elivery Day Year
rds, P	signed be de	þ	Part II. Other significant conditions cont	nbuting to death but not res	ulting in the unde	riying cause give	en in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
		Completed						24a. Was a autop perfor	sv prior to	
VIII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:		all DOA Othe	200	ath (Check only or		Une Oie 2
	nding Phys th. : After this s funeral di	tion; To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c Injun Work	4 140151119 1	dome 5 Resid	ence 6 Other (Sp ow injury occurred	ecity) HOSPICE
Division	tel or Attending s after death. It Director: After ad in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street	factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	e Hospitel 124 hours a e Funeral D letely filled i	Medical (29a. Certifier 1 Sertifying Physic (Check only one) 2 Medical Examina	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death oction and/or inves	curred at the time tigation, in my op	ne, date and place pinion, death occu	e, and due to the curred at the time, o	ause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely		29b. Signature and title of eertifier			29c. License			29d. Date signed (Mor	
	El.		1860	in	n	D00	58410		10/1/09	5
	Pa		30. Name and address of person who con 26266 ARRE	npleted cause of death (Iter	n 23a) (Type, Pri	11) GHUL	SBUR	RIZ.MD	. 2180	1
5 .	Sta Registr	te	31. Date filed (Month Cay Year) 4 20	32 Radietrar's Signs	ture			,		-

			1 - State of Maryland / De Ragistrar	partment of Health and <mark>I</mark> ertificate of Death	Mental Hygie Rag.	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
No.	Physici /Medic		Elmer Landis		October	Day Year 3=15-AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			wathwest funitel	Randeliston	1	Kaltingse
	Funeral		5. Social Security Number 6. Sex 7 7 Age (In yrs. last birthda	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		217-20-3169 80 Yrs.		Feb. 5,	1925 VÄ
	and		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary	ō	Maryland Baltimore Rai	ndallstown		1 ☐ Yes 2 ☑ No
	28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a o		9210 Colorado Ave.	21133		
	deati	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Si	pecify Yes or No-	nited States 14. Race - American Indian,
ဖွ	after or Ite	Fu	1 ☐ Never Married 2 ☑ Married Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWTT	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	o Rican, etc.)	Black, White, etc.
8	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heatile and Mental Hygiene. Deperment of Heatile and Mental Hygiene. Important: If tem 27 is marked other than "natural", or tems 23a or 28a-f show important: If tem 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Madical Exactifier must be notified at once.	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates: WWII	TEL 165 2LANO Specify.		Specify: White
21215-0036	"nati	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work	king 16b	. Kind of Business/Industry
12	withir no. than	E D	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
	Hygie Hygie ther I	ပိ	11th 17. Father's Name (First, Middle, Last)	Test Desk	ne (First, Middle, Maid	C & P Telephone
and	should be ind Mental I) Be				
aryland	mari mati	ပ္	Statton Landi: 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or Ru	ISSIE	Daggy
S	and 2 sealth ar n 27 is			10 Colorado Ave.	- M.	lstown, MD 21133
ē,	f Healtsm		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place) Cem.		Location - City or Town, State
Ë	Pages nent of I ant: If Its arry or o		* XXBurial 2 □ Cremation 3 □ Removal from State '4 □ Donafton 5 □ Other (Specify) Garriso	on Forest Vet.	oct. 4	rrison, MD
altimore,	permit. F Departm Importar any injur	1				
m	Depending Indiana		Muy (1) Celly	Burrier-Queen'f	uneral E	berty Road 21784 lome & Crematory
			23a Part . Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
3	Pn ysicia n		Immediate Cause (Final	1)		Onset and Death
	/Medical		discusse a condition resulting in death) a. Ue to (or as a consequence of):			
	Examiner	_	Sequentially list conditions, b.			
	ed isi	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	and and il-trar	хап	that initiated events resulting in death) Last			
58760,	icate be executed physician and the burial-transit	dical				
89			0.			
Вох	death certifi attending I for use as	ZM	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
m m	The law requires that the death certif sie has been signed by the attending bage 2 should be detached for use ax	Physician/M	1 Yes 2 No 4 Pregnant at time of death	B Ectopic pregnancy Differ (specify)		Month Day Year
о. О	at the de by the a	h	9 LI Onknown			
ś	igned to	þ	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	11.0	o use contribute to the cause of death?
oro	w require been signal	ted	The that there		1 🗆 Yes	2 No 3 Probably 4 □Unknown
Vital Records,	e law has b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>~</u>		Co			performed	death?
<u> </u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: ##		h (Check only one)	
	Phys r this rat dii	2	1 ☐ Yes 2 ☐ No rospital: 1 ☐ Inpatient 2 ☐ EP/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time		ome 5 Residence	6 ☐ Other (Specify)
o	ding P	tion	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation		200. Describe now in	lary occurred
Division of	Attendi r death. cctor: A by the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm		28f. Location (Street	and Number or Rural Route Number,
S	al or	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ate)
	ospit hours uners ty fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours alter deals. To the Funeral Director: After this certifior completely filled in by the funeral director.	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	To T com	Σ	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
	WJL		Alike Hind	143974	CUT	They I Evar
	IOTA		30. Name and address of person who completed cause of death (Item 23a) (Typ	0,0,0	KD	21/33
			31. Date filed (Month, Day, Year) 32. Recentrar's Signature	Hopital Pan	Ashistom	- maigloshd
	Sta Registra		OCT 0 3 2005	1		/

State of Maryland / Department of Health and Mental Hygiere 05 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:00 a^M OCTOBER 9 2005 Franklin Mundie, Jr. James /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**1**€ M 2 □ F Aug. 7, 1931 Washington, DC Director 578-40-4401 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State item 27 is marked other than "natural", or itame 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 🙀 No St. Mary's Leonardtown Maryland | Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43563 Blake Creek Road 20650 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

15 Stes 2 No 1952If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter HVAC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Franklin Mundie, Sr. Mary Loretta Langyher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth W. Mundie/Wife 43563 Blake Creek Road, Leonardtown, Maryland 20650 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State = permit. Page Depertment (importent: if any injury or St. George's CH Cem. 10/14/2005 4 ☐ Donation 5 ☐ Other (Specify) Valley Lee, Maryland 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Road, Charlotte Hall, MD 20622 21. Signature of Funeral Service Licensee 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sephc Shock **Physician** HOUSS /Medical Due to (or as a consequence of) Examiner Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): toat infection Days the attending physician and ned for use as the burial-transit US NOIGY Due to (or as a consequence of): 68760. ISCHEMIC Cardiomyopathy Years Physician/Medical thet 98 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic organiancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, mellitus 1 Yes 2 No 3 Probably 4 Unknown Diabortes Completed commany artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Benish postabe hipertophy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Punerel Director; completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number 10.11.05 120061719 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, MD 20636 Dhananjay Bhavsar 31. Date filed (Month, Day,) State Registrar 1:0: 2 2 700g DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NAME: Mac Master, Mary permit. Pagas 1 and 2 should be filled within 72 h. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trained.

Funeral

Director

item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per Dr., G848, 10/28/05dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:35P ^M Mary Alvina MacMaster October 0 8, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Reeders Memorial Home Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M XX F Yrs. 577-32-4014 79 10/07/1926 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD Hagerstown 1 ☐ Yes 2 X No Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11103 Parkwood Drive 21742 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Economist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Peter Rickmeier Elizabeth Louise Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11103 Parkwood Drive, Hagerstown, MD 21742 David B. MacMaster / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Cremator. 10/10/2005 Smithsburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune at Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Chrinic disease or condition resulting in death) Chrones Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Be

Examiner death certificate be axecuted burial-transit attending physician for use as the burial ed by the a To the Hospitel or Attending Physicien: The law requires that the baen signed bestored Certification: To death. in by 24 hours Medical

Physician

/Medical

					1 Yes 2 N	o 1∐Yes
25. Was case referred to medical			26. F	Place of Death (C	heck only one)	
examiner? 1 Yes 2 1 46	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Other: 4	ursing Home	5 Residence	6 ☐Other (Specify
27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	28d.	Describe how inju	ury occurred

Pending investigation atural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler

10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Dr. Praveen Bolarum

Year)

2005

4 Homicide

340 Mills Street, Hagerstown, MD 21740/ 301-739-7100

D0061223

10/09/2005

State Registra

medistrar's Signature

DHMH 17 Rev 1/2001

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 1 15

	1	- State Registrar		Cei	tificate of l	Death	Re	g. No.	0,1020	
Physician /Medical	1	Decedent's Name (First, Middle, Lasi	TE	MAI	VDEL		2. Date of Death Month		3. Time of Death	
Examiner		a. Fecility Name (If not institution, give Hebrew Home of G		igton	4b. City, Town, or Rockvill	Location of Death		4c. County of De Montgo		
Funeral Director	0	75 25 3636	x 7. Age (In yr 83	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth July 28	Year 1922 B	intholace (State or Fore Country) rooklyn, N	
natural', or Items 23a or 28a-f show bleal Exemires must be notified at sted by Funeral Director	-	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Lim	
-f show		MD Montgomen		Rockvi					1√ Yes 2□	
23a or 28a-f showed the control of t		Oe. Street and Number 6105 Montrose			10f. Zip Code 2085	52	10	g. Citizen of What C	Country?	
or Items mirrer m	m	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify: W	ite, etc.	
re than "natural; it, the Medical Exe		15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	lent's Usual Occupa	ation during most of working	10	6b. Kind of Busines	s/Industry	
mpi		Elementary/Secondary (0-12)	College (1-4or 5+)	Teache	OO NOT use retired,)				
An organization to research and mental riggener. Important: If ten 751 is marked other than "natural; any injury or other traumatic event, Ir a Medical Extension of the traumatic event, Ir a Medical Extension or other traumatic event, Ir a Medical Extension or other traumatic event, Ir a Medical Extension or other traumatic event, Ir a Medical Extension or other traumatic events. To Be Completed by		7. Father's Name (First, Middle, Last) Irving Cla	aman	reactie		Educat aiden Sumame) e Rosenbl				
127 is mar 127 is mar		19a. Informant's Name/Relationship (7) Pamela Pelcovits	ype, Print) 5 , daughter	19b. Mailin 6 Sa	g Address (Street a ddlerock	and Number or Rura Court, Si	Route Number, (Llver Spi	City or Town, State,	Zip Code) 20902	
ant: If Item ant: or othe	2	Oa. Method of Disposition 1 ☐ Fourial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State Un	Place of Disposicemetery, crem ion Fie	natory or other place	9)		Oc. Location - City o		
any inj		21. Signature of Fundral Service Licens	Byle			s of Facility Tor			neral Home 20012	
/sician ledical aminer		23a. Part1. Enter the disease, or complete shock, or heart lailure. List only of mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to immediate	a. Due to Tor as a conse	MON equence of):	///	g, such as cardiac of	respiratory arres	51,	Approximate Interval Between Onset and Death	
attending physician and for use as the burial-transit clary.	1	ause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	Due to (or as a conse	1611	714			7		
the attendand for us		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown*	3c. If yes, outcome of preging the second of the second o	tal death 3 🗌	Ectopic pregnancy Other (specify)	23d. Date of de Month	olivery Day Year			
<u>6</u> 8 <u>6</u>		art II. Other significant conditions con	ntributing to death but not re	sulting in the un	derlying cause give	acco use contribute to the cause of death? s 2 No 3 Probably 4 Honknow				
page 2	- -						24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of	
director	1 2	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA Othe	26. Place of Death		ce 6 ☐ Other (Spe	ecify)	
After t funera tion:	2	1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at 2! ? 'es 2 □ No	8d. Describe how	injury occurred		
after deat Director: I in by the ertifical		4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, larm, stre	et, factory, office	21	81. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,	
Sed in De	L									
within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	1	29a. Certifier (Check only one) 1 Scertifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my op	inion, death occurred	d at the time, date	se(s) and manner as a and place, and due I. Date signed (Moni	e to the cause(s)	

State Registrar

31. Date liled (Month, Day, Year) OCT 06 2005

30 Name and address of person who completed cause of death (Item 3a) (Type, Print) Barbara Kalazny, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.27,28a-f,perME.G848,10-21-05 III State of Maryland / Department of Health and Mental Hygiere () 5

34024 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER ¹3, 2005 Physician 8:15A. Christopher John Mason /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HURLOCK
If Under 1 Year
Months Days DORCHESTER 4419 RICHARD WAY If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Min 1**⊠**M 2□F Yrs 219-19-2522 22 1983 Maryland July 18, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location or 28e-f ehow the Medical Examiner must be notified at MD Dorchester Hurlock 1XYes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 217 Glen Oak Circle 21643 USA Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 🗖 No Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) cashier retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperment of Heelth and Mental Hy Importent: If Item 27 Ie marked oth any Injury or other traumatic event any Injury or other traumatic event ang Injury or other traumatic event Be Jerry D. Mason Wanda Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 217 Glen Oak Circle, Hurlock, MD Wanda Mason mother 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. ! 10/7/05 East New Market, MD Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Smoke Inhalation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical ettending phys for use as the use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ∆ Yes 2 No 1 ØYes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1⊠Yes 2 No ihis within 24 hours effer death.

To the Funerel Director: Affer thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) Fnd Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes ZXXNo 2X Accident 10-3-2005 7:46 A House fire 6 ☐ Could not be 3 Suicide 28f. Location (Street and Nymber or Rural Route Number City or Town, State) 4419 Richard Way Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Residence Hurlock, MD To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME Hallan md OCTOBER 4,2005 leted cause of death (Item 28a) (Type, Print) Penn Street Baltimore, Maryland 21201

State Registrar LAW mel

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Richard Moore October 3, 2005 1:45 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1082 Pemberton Lane Lothian Anne Arundel 5. Social Security Number **Funeral** last birthday) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1**X** M 2 □ F 60 241-68-7501 Director North Carolina Jul 10, 1945 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I tem 27 is marked other than "natural" ~ " any injury or other traumatic avar. t0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Director Lothian 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1082 Pemberton 20711 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Black Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Accounting Firm Accountant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Richard 2 Moore Florine Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Moore (wife) 1082 Pemberton Lane Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 1 Mag Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Our Lady's Cemetery 2005 Leonardtown, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Ineral Service Licensee J. &off 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1 Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (ancer Priysician 1420 Bhreen /Medical Due to (or as a consequence of) Examiner mons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit nding physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed; certificate 22 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To this 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending investigation | Director: / 2 Accident 1 □ Yes 2 □ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funerel Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Knopt TevinB 31. Date filed (Month, Day, Year) State 32. Registras s Signature 2005 ▶ Registrar

State of Maryland / Department of Health and Mental Hygiege 0 5 1 - For State Registrar 34026 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Claire Elizabeth Mallicote October 2, 2005 /Medical 8:30 a 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6401 McKendree Road Dunkirk Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 212 F Months Director 222-24-6171 63 1942 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If a Marie if E. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☑ No MD Anne Arundel Dunkirk 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6401 McKendree Road Funeral 20754 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Completed by 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 office supply store owner retail office supply 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ೭ William Kelly Hertz Rosella Ruth Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack A. Mallicote, spouse 6401 McKendree Road, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10-07-05 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10 Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Breast Cancer 8.5 years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year P.0. 5 Other (specify) ☐ Yes 2 XNo ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performed? this certificate 1∐ Yes 2 No Hospital or Attending Physician: 4 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: JO. 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation after death. Director: Aft 1 Tes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
26 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D08118 October 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Watkins, MD, 900 Bestgate Rd., Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registra Signature State 5 2005 Registrar OCT -

State of Maryland / Department of Health and Mental Hygiene Amend Item #26 Per Phy G 848 rtificate Rispenth . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia Mann October 2005 0600 A M 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morning Side House Parkville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, March 5 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 200 F Director 212-38-9061 90 1915 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show item 27 is marked other then "natural", or items 23a or 28e-f shov other treumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 425 Pangborn Blvd. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other treumstic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lynn McCune 2 Blanche Raye Coss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 East Joppa Rd. #2603 Towson, Maryland 21286 Deimel / Daughter Patricia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 10/17/2005 Hagerstown Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between AOnset and Death Immediate Cause (Final disease or condition resulting in death) Physician rension Man /Medical Due to (or as a co equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by icate has been siç . page 2 should b 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2□ No 1 Yes 2/2/No 1 TYes To the Hospitel or Attending Physicien: funeral director Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No 1 Yes Other: Medical Certification: To 2 ER/Outpatient 5 Residence 6 Other (Specify) 3 DOA XX Nursing Home this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After 1 ANatural 2 Accident 5 Pending i hours after death.

unerel Director: After the function of t investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerei Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mohammad R. Rahnu MD. 9512 Harford Rd. Suite 4 Baltimore Maryland 21234 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 9 2005 Registrar

CT O5-06635 Melvin, Lon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

in,	Lonnie	2	For State	State of Maryland / Department of Health and Mental Hygiene 2005 34028								
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Death	Reg. 2. Date of Death	3. Time of Death					
	Physicia	ın	1. Decedent's Name (First, Middle, Last)	ALPHONSO	MELVA	Month I	Day Year					
	/Medic Examin		4a. Facility Name (If not institution, give :		4b. City, Town, or Location of Death	September	30, 2005 12:37 A ^m					
	LXamiin	G1	Peninsula Regiona	1 Medical Center	Salisbury		Wicomico					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye.	9. Birthplace (State or Foreign Country)					
	Director	-	069-66 - 770st / Usual Residence of Decedent	M 2 Yrs.		11-4-	76 // /					
0	W ==		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits					
M	High	to	Mr WICOT	NICO SALIS	BURY		1 Yes 2 □ No					
i.	or 28	Oire	10e. Street and Number	Λ .	10f. Zip Code	10g.	Citizen of What Country?					
4	238	rail	607- KELVIN		Was Decedent of Hispanic Origin? (Sp	noify You as No	14. Race - American Indian,					
10	iner.	Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 Yes 22 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.					
036	naturel', or iteme 23a or 28e-1 show dicel Examiner must be notified at	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2ÆNo Specity:		Specify: BLACK					
21215-0036	natur	Completed	15. Decedent's Edu (Specify only highest grade	e completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b	. Kind of Business/Industry					
121	hen.	ď	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		DERDUE					
	Hygie other ant, it	ပိ	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	den Sumame)					
Maryland	permin. Teges I and 2 should be used within 12 hours are deen will the waysal poperment of Health and Mental Hydene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat must be notified at ODEs.	To Be	HERMAN	MELVIN	LOVIE	PARI	KER MELVIN					
lary	and N		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Maili	ng Address (Street and Number or Rui	al Route Number, Cit	ty or Town, State, Zip Code)					
	m 27		SHERMANM	ELVIN ~ DROTHER = 31 20b. Place of Dispo	196 CARIOCO BO	DELMAI Date 20c	L Cation - City or Town, State					
Jore	nent of H int: If ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	temoval from State cemetery, crea	matory or other place)	/						
Baltimore,	Department of important: If end injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	SPRING	HILL CEM, 10/8 2. Name and Address of Facility	ENNIE	EBRON MID					
Ba	Depe impo		Princelle	Knords 9	19-11) TSARELLAS	ST. SAUSI	RURU MA 21801					
H			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do not en	ter the mode of dying, such as cardiac		Approximate Interval Between					
	hysician		Immediate Cause (Final disease or condition	Gunshot wound	Onset and Death							
	/Medical xaminer		resulting in death)	Due to (or as a consequence of):								
		-	Sequentially list conditions,	Due to (or as a nonsequence of):								
4	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
0	ien an urial-tr	Exa	resulting in death) Last	Due to (or as a consequence of):								
8760,	physicien and the burial-transit	dicai		J								
	attending for use as	by Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnancy	•		23d. Date of delivery					
Box 6	d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5 [□Ectopic pregnancy □ Other (specify)		Month Day Year					
P.O.	by the	hys	9 Unknown	9□ Unknown		-						
	signed by the a	by	Part II. Other significant conditions con	ntributing to death but not resulting in the u	underlying cause given in Part I.		co use contribute to the cause of death? 2 ⊠No 3 □ Probably 4 □Unknown					
Division of Vital Records,	been s	Completed		The state of the s								
Rec	hes hes	du				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?					
tal	certificete	Be Co	25. Was case referred to medical		26. Place of Dea	th (Check only one)	No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
Y	g ig		examiner? 1⊠ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🗗 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	ome 5 Residence	e 6 □Other (Specify)					
0 8	the L	ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	njury occurred was shot					
isio	r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	9-29-05 11:44 28e. Place of Injury - At home, farm, st	M 1 Yes 2 12No		t and Number or Rural Route Number,					
Div	after Direction by	Certification: To	4 Homicide determined	building, etc. (Specify)		City or Town, Si	tale) you west Rd					
	within 24 hours after death. To the Funeral Director: A completely filled in by the t			sician: To the best of my knowledge, deat	th occurred at the time, date and place,		e(s) and manner as stated.					
1	the Fu	Medical	one)	ner: On the basis of examination and/or in and manner stated.								
	Z M C	2:	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)					
	0,1		30 Name and address of person who co	ompleted cause of death (Item 23a) (Type,	OCME	Sep	otember 30, 2005					
	IVVI		LING LI M	D		Baltimore	e, Maryland 21201					
	Sta		31. Date filed (Month, Day, Year) OCT 0 4 21	32. Figistrar's Signature								
ŧ	Registr	ar	0010 120	MARKEY IT. L	Carle)							

State of Maryland / Department of Health and Mental Hygiene 34029 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 27, 2005 Sept. 8:20AM George William Moinichen /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Manor Care-Potomac Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. March 25, 1938 Director 67 Illinois 355-30-1246 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Inttell them 27 is marked other than "natural; or items 23a or 28a-f show ary or other treumatic event, the Medical Evariener must be multired at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Funeral Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3240 Hewitt Avenue #43 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jule Ritter Sigfred Lie Moinichen ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Neme of cemetery, crematory or other place) Peter Moinichen - Brother Illinois 60304 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once, 10-2-05 Falls Church, VA National Crematory 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Uneral S National Funeral Home 7482 Lee Hwy Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis Examiner Due to (or as a consequence of): by Physician/Medical Examiner Esophageal Cancer Mestastasis or Attending Physicien: The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): end G-Tube Feeding Division of Vital Records, P.O. Box 68760. attending physician for use as the burie Due to (or as a consequence of): Bilaterial Pleural Effusion Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 1 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ To the Hospital or Attending Phys within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral directors. this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Matural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a: Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie September 27. 2005 D-2027430. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA, MD 20817 KIRTI VOHRA, MD 7710 BRADLEY BLVD, 31. Date filed (Month, Day, Year) State Registrar OCT 0 4 2005

DHMH 16 Rev 6/95

with the

72 hours after death

Pneumonia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death

Reg. No.

Year

Black, White, etc.

2005

3. Time of Death

12:16 p^M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

3 days

3 days

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

October 2, 2005

1⊠Yes 2 No

Physician /Medical Examiner

Immediate Cause (Final disease or condition

1 - For State Registrar

Examine burial-translt and Physician/Medical es the use detached for Be Completed by should be page 2 funeral director, Medical Certification; To this the

filled in by

or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

resulting in death) Due to (or as a consequence of): b. Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1X Yes 2 □ No Chronic Obstructive Lung Disease 24a. Was an autopsy performed? 1□ Yes 2√ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director; A State Registrar

Riad Dakheel, MD

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Mitchellville Road, Suite B216, Bowie, Maryland 20716

D26492

31. Date filed (Month, Day, Year)

OCT 0 5 2005

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name /First Middle Last Month 09 05 **Physician** 4:25 P M Essie G. MArtin /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital MOntgomery Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01 27 20 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 F 85 579-30-4881 South Carolina Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Itame 23s or 28s-1 show the Medical Examinar must be notified at 1X Yes 2 No Washington D. C. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 USA 3923 8th. Street N.W. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Baltimore, Maryland 21215-0036 Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 h. I Hygiene. other than "natu 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U. S. Government Custodian permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygie Important: If Item 27 is marked other 1 any injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Issac Graves Minnie Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bennie L. Martin/Son 3923 8th. St. N.W. Washington, D.C. 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Pk. 10-8-05 LAndover, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS SYNDROME

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Physician /Medical BILATERAL PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PRESSURE SORE INFECTION, TOTAL CARE, END 1 Yes 2 No 3 Probably 4 Unknown STAGE RENAL DISEASE, DIAJETES MALINS; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? RESPIRATORY FAIWRE, DIFFUSE VASLUAR DISCHIE 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 11☑Inpatient 2☐ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or A To the Hospitel c within 24 hours af To the Funerel Di Certifying Physician: To the best of my knowledge, Jeath occurred at the time, date and blace, and due in the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPTEMBER 30th, 2005 · swamburen D 5 3 3 67 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYAMSUMAR. RAJAN 10810. DARNESOWN ROAD, SUITE: 202, GAITHERSILVAG, MO: 20874. 31. Date filed (Month, Day, Year) State Believe & Sports Registrar

State of Maryland / Department of Health and Mental Hygiene 05 34032 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year William George Manuel October 1, 2005 4:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Healthcare Center Waldorf Charles If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F 86 Yrs. Director 175-07-4945 Nov. 6, 1918 Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exampler must be inclified at 1 Tes X No Directo Prince George's Marvland Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20613 USA 17626 Aquasco Road death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer comparation of Heelth and Mentai Hyglene. Importent; if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercised page. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Public Health Consultant US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ William P. Manuel Harriett Wilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Wright - Daughter 17626 Aquasco Road, Brandywine, MD 20613 20b, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 10-3-2005 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00053 P. O. Box 156 Huntt Funeral Home Waldorf, MD 20604-0156 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer 1 yr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) buriel-transit and Due to (or as a consequence of) ed by the attending physiclen detached for use as the buriel Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 2 No Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 1 Yes 2 No P 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation s after dea. rei Director; Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of q ertifie r 29c. License number an D44436 octo. 04 2005 Ø erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Natel, 102 Paul Mellon Ct., #102, Waldorf, MD 20602 Ashvin J. 31. Date filed (Month, Day, Year) gistrar's Signature 32. P State OCT 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 0415 AM Physician October Mueller 2005 harlotte /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Kent nester town Kiver Center Health If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. FEB. 17, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 1917 **Funeral** Months 1 ☐ M 2 🂢 F 88 330-01-1896 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. It a Macical Evanting It was to notified at once. 1 X Yes 2 ☐ No CHESTERTOWN MD KENT **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 USA 427 HERON POINT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 ANo 11 Marital Status 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANDREA C.M. ROSENDAHL JULIUS HENRY WALDECKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 427 HERON POINT, CHESTERTOWN, MD 21620 MAX MUELLER/HUSBAND Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION OCT.6,2005 STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1/2 years SYNDROME **Physician** MYELODYSPLASTIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and al-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 200 No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 🗷 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: the Hospital or Attending hin 24 hours after death. the Funeral Director: After Injury Natural 5 Pending 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0041587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. HE LENANOBLE MD 21620 (7)5 CHESTERTUNN SPEE 12 32_Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, which is the formulation of the funeral director, completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis o and manner st	f examinatio	ledge, deat on and/or in	h occurred at the tr vestigation, in my	me, date and place, a opinion, death occurre	and due to the car ad at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)	
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-	2		30. Name and address of person who									
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	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 187–24–5711 73	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		th ay, Year)	9. Birthplace (State or Foreign Country)		
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			Long of the		4584	19	be	toben 1	7,2005		
			30. Name and address of person who completed cause of death (Item 23a) RODNEY DONTIAM, D.O. 196 BOWST			MD 2	1921				
ř	Stat Registra		31. Date filed (Month, Day, Year) \$2. Registrar's Signature	Corne	the state of the s	1 6					

			For State Registrar		State of Ma	aryland	/ Departi	ment of F icate of I	lealth and Death	Mental Hy	gie 2 e 05	34036	
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Baltimore,	# O - L		20a. Method of Disposition 1 ☐ Surial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot		emoval from State	Spr	ce of Disposition inghill Garden	ry or other place Memory	107	Date 5/05	20c. Location - Cit	MD	
Balt	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Sc	Felow	in Je	CFS	5(DI PHOM	HITT KO	1., Salis	soury, MU	al Association 21804	
Ī			23a. Part1. Enter the diseashock, or heart failure	ase, or compli e. List only or	cations the caused ne cause on each lin	the death.	Do not enter th			ac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- a	Due to (or as a	tie	hung of	Car	ncer			one month	
	Examiner		Conventing the list condition		Due to (or as a	conseque	U U						
2	p #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	• 1	Due to (or as a	a conseque	nce of).						
	xecute al-tran	causé. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								-			
28/60	ficate be executed physicien and is the burial-transit	edicai E			·								
_	entifica ling ph e as th		IF FEMALE:										
O. Box	The law requires that the death certif te hes been signed by the attending rage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 1 1 1 1 1 1 1 1								23d. Date of delivery Month Day Year		
rds, P.	quires that n signed by	Ď	Part ii. Other significant conditions continuuming to death but not resulting in the underlying cause given in Part ii.								/	use contribute to the cause of death?	
Vital Records,	The law requires ate hes been si page 2 should l	Completed						-		24a. Was auto perfe	psy prio		
Ta Ta	iclan: Th certificate rector, pag	BeC	25. Was case referred to mexaminer?	-	CECTI COM CONTRACTOR	-2000			26. Place of De	eath Check only	1	Yes 2	
	Ing Phys Vier this uneral dii	၉	1 Yes No 27. Manner of Death Natural 5 1	Pending	28a. Date of Injury (Month, Day	y 2	R/Outpatient 3 8b. Time of Injury	28c. Injur	ther: 4 Nursing Home 5 Residence 6 Other (Specify)			Specify)	
Division of	I or Attending after death. Director: After	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the tr	Medical C	29a. Certifier (Check only one)	ertifying Phys edical Examin	sician: To the best of ner: On the basis of and manner sta	examination	edge, death occ n and/or investi	curred at the ting gation, in my o	ne, date and plac pinion, death occ	e, and due to the surred at the time.	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of	certifier	1/11	//	1	29c. Licens		-	29d. Date signed (A		
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できるが	Sta Registr		31. Date filed (Month, Day,	Year). 0 4 20	05 32. Sigistra	r's Signatur	bspice	de la		•	0)		

		4	For State Registrar	State of Marylan	Certifica	ate of Dea	th	Reg. N		34031
	Physici		1. Decedent's Name (First, Middle, Last) Helen Marie	e O'Reilly				Date of Death Month D	ay O5 Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number) - WoSPITAL		ty, Town, or Locati	and D		c. County of Deat Allega	
ار م م	Funeral Director		5. Social Security Number 6. Sex 210-14-6215	7. Age (In yrs. i	/ast birthday) If Und Month		rs Min.	Date of Birth (Month, Day, Yeal OV. 3, 19	9. Birt Peni	hplace (State or Foreign untry) Isylvania
	Maryland -f ahow lind al	tor	Usual Residence of Decedent 10a. State 10b. County MD. Allegany		y, Town or Location sternport					10d. Inside City Limits 1 ☐ Yes 2XXNo
	with the 3a or 28a	i Director	10e. Street and Number 22518 Minnetonka	Ave.	10f.	Zip Code 21562			itizen of What Co	•
036	72 hours after death with the Maryland natural; or items 23s or 28s-f show deal Examiner must be puillfied at	by Funeral	11. Marital Status 1 Never Married **Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 22010 If Yes, Give Year or Dates:		cedent of Hispanic pecify Cuban, Mex Spec		y Yes or No- an, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within ene. then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's U (Give kind of life. DO NOT	work done during i Fuse retired)	most of working		Kind of Business/	
	filed Hygi ther int,	Be Co	17. Father's Name (First, Middle, Last)			18. M	other's Name (F	First, Middle, Maide	en Sumame)	
Maryland		P	Louis Buck		10h Mailing Addr	nes (Street and Nu	Anna E	Bucko Boute Number, City	or Town State	Zin Code)
	s 1 and 2 should I Health and Mer Itam 27 is marks other traumatic		Donald O'Reilly / I							yland 21562
altimore,	90 = 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Place of Disposition (/ emetery, crematory of Peters C	or other place)	10/14 2005	/	Location - City or sternport	Town, State L, Maryland
Bait	permit. Pag Depertment Important: I any Injury o once.		21. Signature of Funeral Service License 7. Warm	Bal		and Address of F	Dou.	l Funeral ernport,		1 21562
*	Physician		23a. Part I. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death te cause on each tine. PulseLes		TRLCAL	Λ		PACIFICATION AND AND AND AND AND AND AND AND AND AN	Approximate fnterval Between Onset and Death 20 minutes
100	/Medical Examiner		resulting in death)	Due to (or as a consequence of the consequence of t	uence of):	INFA		,		12 HOURS.
	nsit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence						
68760,	ficate be executed physicien and is the burial-transit	edical Examin	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	I death 3 □Ectopic	c pregnancy (specify)			23d. Date of del Month	ivery Day Year
<u> </u>	es the	þ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlyin	g cause given in P	art I.	23e. Did tobacco		the cause of death?
of Vital Records,	9 - 9	Completed						24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of
Œ		10				26.0	lace of Death (C	Check only one)		
V.	ician: Sertifica ector. p	Be	25. Was case referred to medical examiner?	Insnital:		Other				
	ling Physician: After this certific	To Be	examiner? 1 Yes No 27. Manner of Death 1 Autural 5 Pending	28a. Date of fnjury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	Other	280	5 Residence		cify)
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	or Attending Physician: for death. irector: After this certific by the funeral director.	Certification; To Be	examiner? 1 Yes No 27. Manner of Death 1 Actival 2 Accident 3 Suicide 4 Homicide 29a. Certifier 2 Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Cert	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M ome, farm, street, fac y)	DOA Other: 4 [28c. Injury at Work? 1 [Yes :	286 2 No 28f	d. Describe how in Location (Street a City or Town, Sta	and Number or Rute) (s) and manner as	ural Route Number,
	utending Physicien: death. ctor: After this certific / the funeral director.	To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifician: To the best of my known on the control of the basis of examina and manner stated.	28b. Time of Injury M ome, farm, street, fac y) owledge, death occurr tion and/or investigat	DOA Other: 4 [28c. Injury at Work? 1 [Yes : tory, office red at the time, dat ion, in my opinion, 29c. License numb	28d 2 No 28f 28f e and place, and death occurred	d. Describe how injunction of the cause at the time, date a	and Number or Rute) (s) and manner as nd place, and due obate signed (Mont.)	stated. to the cause(s) h. Day, Year)
	or Attending Physician: for death. irector: After this certific by the funeral director.	edical Certification; To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifician: To the best of my known on the control of the basis of examina and manner stated.	28b. Time of Injury M ome, farm, street, fac y) owledge, death occurr tion and/or investigat	DOA Other: 4 [28c. Injury at Work? 1 [Yes : tory, office red at the time, dat ion, in my opinion, 29c. License numb	28d 2 No 28f 28f e and place, and death occurred	d. Describe how injunction of the cause at the time, date a	and Number or Rute) (s) and manner as nd place, and due obate signed (Mont.)	stated. to the cause(s) h. Day, Year)
	or Attending Physician: for death. irector: After this certific by the funeral director.	edical Certification; To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifications: To the best of my known and manner stated.	28b. Time of Injury M ome, farm, street, fac y) owledge, death occurr tion and/or investigat	DOA Other: 4 [28c. Injury at Work? 1 [Yes : tory, office red at the time, dat ion, in my opinion, 29c. License numb	28d 2 No 28f 28f e and place, and death occurred	d. Describe how injunction of the cause at the time, date a	and Number or Rute) (s) and manner as nd place, and due obate signed (Mont.)	stated. to the cause(s) h. Day, Year)

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 3.15 PM Lucille Gloria Oldland 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford Upper Chesapeake Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 12/13/1940 Birthplace (State or Foreign Country)
 Mass. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🔀 F 64 Yrs. Director 012-30-5132 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 No Director Harford Aberdeen 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21001 412 Wye Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1,959–60 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Menta! Hyglena. Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst U.S.Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Spear Sabino Monica 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health :: If item 27 i 407 Union St. Louise A. Oldland (Daughter in Law Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R. A. Ferris & Co. 10/6/05 West Chester, PA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Car o Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complic it is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one buse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non small cell Ling concer with Brain metastasis Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of signad by the attending physician and deed be detached for usa as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760, Physician/Medicai Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 2**X** No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 Do056607 - AND 30. Name address of person who completed cause of death (Item 23a) (Type, Print) S. ATWOOD Rd, BELASR ANGELO #205, · MD 21014 602 JOSEPH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State ive & Sparke 6 2005 Registrar

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te of Maryland / Department of Health and Mental Hygie (20) 5	34039	
Certificate of Death		

1 V .L.	N ONLET		For	State of M	laryland	d / Depa	artment	of H	ealth a	and Me	ntal Hy	giep	e() ()	5	340	39
			1 - State Registrar			Ce	rtificate	of L	Death			Reg. N				
	Physici		Decedent's Name (First, Midd KEVIN	lle, Last) ONLEY						2	Date of De Month OCT	D	2005	Year	3. Time of 1205	Death PM
	/Medio Examir		4a. Facility Name (If not institution	on, give street and number)		4b. City, T	rown, or	Location o	of Death	0020	-	c. County	of Death		
	LAdillii	ICI	PRINCE GEORGES	-				EVER			PRINCE GEOR			EORGES		
	Funeral Director		5. Social Security Number 577–80–0683	6. Sex 7. A	ge (In yrs. Ia 45	s <i>t birthday)</i> Yrs.	Months	Days	Hours	Min.	B. Date of Bird (Month, Date) Octobe:				place (State on ntry) shingt	
	D.		Usual Residence of Decedent										V			
	Marylan f ehow	lor	MD Princ	ce George's		Now C	arro1	1 ton							10d. Inside Cit 1 🛣 Yes	•
	158 288	Director	10e. Street and Number	ce deorge 3		HCW C	10f. Zip		<u> </u>			10a. C	itizen of V	Vhat Cou	ntry?	
	th with	ai Di	7719 Riverdal	e Rd # 302					0784				U.S.	Α.	•	
980	72 hours after deeth with the Maryland natural; or itema 23a or 28a-f ehow dical Examinar must be notified at	by Funeral	11. Marital Status 1 ∰ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	?		Was Decedent Yes, special Yes 2	fy Cuba	spanic Orig n, Mexican Specify:	gin? (Speci n, Puerto Ri	fy Yes or No can, etc.)	-	Blac	14. Race - American Indian, Black, White, etc. Specify: Black		
5-0	72 ho	eted	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual kind of work DO NOT use	Occupa	ation during most	t of working	,	16b. l	Kind of Bu	isiness/Ir	ndustry	
21215-0036	within ene. than *	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)		ustod:)				Gove	Trom o	nt	
9	Hyger H	8	17. Father's Name (First, Middle,	Last)			us cou.	Lan	18. Mothe	or's Name (First, Middle,	Maide			ш	
Maryland	9 5 5 5	To B	Oswald Jeron	ne Onlev					Ti 1	llie	Beas	1ev				
ary	and 2 sh salth and n 27 is m	-	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a			Route Numbe		or Town,	State, Zij	o Code)	
			Tillie M. On	ley/Mother		5001	Emo S	tree	t Cap	oitol	Heigh	ts,	Mary	1and	20743	
Baltimore,	00-		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)				sition (Nam natory or oth			Dai 10/9/0			nton,	•	own, State 71and	
Balti	permit. Pag Department important: i any injury o once.		21. Signature of Funeral Service	Licensee		1	2. Name and 7474 L			-	B. Je Landov				al Home I 2078	
			23a. Part1. Enter the disease, shock, or heart failure. Lis	r complications that cause	d the death.	Do not ent	er the mode	of dying	g, such as	cardiac or r	respiratory ar	rest,			Approximate Interval Bety	
	Physician		Immediate Cause (Final disease or condition	An			secti								Onset and D	
	/Medical		resulting in death)	Due to (or as			, , , , ,									
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	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a conseque	ence of):										
	and -trans	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	s a conseque	ence of):		-								
8760,	cate be executed physicien and the burial-transit	dicai E			- u 0000qu	o.,,,,										
687		0 1														
O. Box	The law requires that the deeth certified has been signed by the attending I page 2 should be detached for use es	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal o	death 3	Ectopic pre Other (spe						23d. Date Mor			ear
ص	that		Part II. Other significant conditi	ions contributing to death	but not resul	ting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco	use contr	ibute to t	he cause of de	eath?
rds	w requires been sign should be	ed by	Hyperteus	we Carde	ovas	cula	1D	(Sec	ese		1 🗆 Y	es 2	!□No	3 ☐ Prot	pably 4 DU	nknown
vision of Vital Records, P.O.	The law resete has be page 2 sho	Completed	v								24a. Was autop perfor	sy	y prior to completion of cause of death?		vailable iuse of	
25. Was case referred to medical examiner? Hospital: Was case referred to medical examiner? Hospital: Was case referred to medical examiner?					of Death /				/1							
25. Was case referred to medical examiner? 1					Other											
o uo	After fune	tion: T	27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Date of Inj	ury 2	28b. Time of Injury		c. Injury Work		28	d. Describe h					
ivisi	or Attending ter death. irector: After n by the fune	rtification;	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	ijury - At hon itc. (Specity)	ne, farm, str					f. Location (S City or Tow			er or Rura	al Route Numb	007,

To the Hospital or within 24 hours afte To the Funeral Dirac completely filled in L

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

State Registrar rud

31. Date filed (Month, Day, Year)
OCT 9 5 2005

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

OCT. 4, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. F.

			1 - For State Ragistrar		Cer	tificate of L	eaith and it Death	Re	g. No.	34040	
	Physici /Medio	cal	Decedent's Name (First, Middle, Last) SUN OK PARK 4a. Facility Name (If not institution, give seems)			4b. City, Town, or	Location of Death	2. Date of Deat Month OCTOBE	Day Year		
	Examir Funeral Director	ner	CASEY HOUSE 5. Social Security Number 6. Sex	7. Age (lr	n yrs. last birthday) 1 Yrs.	ROCKVII		8. Date of Birth (Month, Day,	MONTGO year) 9. Bir		
	D	ior	Usual Residence of Decedent 10a. State 10b. County MD MONTGO		oc. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	death with the Maryland me 23a or 28e-f show r mast be notified at	ai Director	10e. Street and Number 4011 RANDOLPH	ROAD		10f. Zip Code	20902		10g. Citizen of What Country? U.S.A		
38	urs after dea bi', or iteme Examiner m	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar I□Yes 2□X10	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
Maryland 21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or iteme 23a or 28e-1 show event, it a Madical Examinar must be notified at	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	lent's Usual Occupa kind of work done di DO NOT use retired) HOUSEW	uring most of work	sing	16b. Kind of Business		
land z		To Be Co	12 17. Father's Name (First, Middle, Last) TAE SUN PARK					e (First, Middle, A SOON			
	s 1 end 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty, CHONG C YIM 20a. Method of Disposition	/ DAUGHTE		1 RANDOI	LPH RD,	WHEATO	City or Town, State, 200 MD 200. Location - City or	02	
Baltimore,	permit. Pages Department of the important: If ite any injury or of once.		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature Funeral Donation 5 License	emoval from State	NORBECK	natory or other place MEMORIA) AL10/.	5/05	OLNEY MD	ERAL SERV.	
ñ	Ped International Control		shock, or heart failure. List only or	cations that caused the						MD 20772 Approximate Interval Between Onset and Death	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co		ACRANIAI	L HEMOR	RHAGE			
68/60,	ificate be executed g physicien and as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
O. Box 68/	ath certif ittending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{ENO} \) 9 \(\text{Unknown} \) Unknown	3c. If yes, outcome of p 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year	
J.	w requires thet the de been signed by the a should be detached f	<u>ام</u>	Part II. Other significant conditions con	atributing to death but no	ot resulting in the ur	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to s 2√2 No 3 ☐ Pr	the cause of death?	
Vital Records,	The law ate has b page 2 s	Completed						24a. Was ar autopsy perform 1 ☐ Yes 2	prior to death?	utopsy findings available completion of cause of	
Ĕ	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Iospital:	-67.50/0	Othe		h (Check only one			
Division of	or Attending Physician: ter death. ifrector: After this certific n by the funeral director,	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing Fic	ome 5 ☐ Reside 28d. Describe ho		city) HOSPICE	
Divis	를 를 들	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	Specify)			City or Town			
	To the Hospital within 24 hours e To the Funeral I completely filled	Medicai	(Check only one) 2 Medical Examinate of certifier	ner: On the basis of exa and manner stated	amination and/or inv	restigation, in my op	inion, death occur	red at the time, da	usa(s) and marinar as ite and place, and due od. Date signed (Monto	to the cause(s)	
)	6 18 1		Ellest 1		- mo	04	1248		10/03/	05	
2	Sta	ate	30. Name and address of person who co CHARLES HARRI 31. Date filed (Month, Day, Year)		MUNCAS Signature	TER MILI	RD, R	OCKVILL	E MD 20	855	
	Regist		OCT 0 6 2005	Floring.	Il Some	100					

State of Maryland / Department of Health and Mental Hygiepen 05 34041 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:30 a^M Catherine C. Pilipauskis October 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carolina Hospice Home Denton Caroline If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2X F Yrs. Director 577-18-5621 85 March 14, 1920 Washington, DC Usual Residence of Decedent 10c. City Town or Location 10a State 10h County 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28e-f show treumatic event, it a Medical Examinat mast be redified at 1 X Yes 2 No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10553 Orly Drive 21629 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌣 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 Tyes 2 No. Specify: White Specify: þ lf Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ith and Mental h Be George P. Duvall, Sr. Anne L. Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Mary Ann Myers/Daughter 10553 Orly Drive, Denton, Maryland 21629 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Fort Lincoln Cemetery 10/6/2005 1 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland injury 22. Name and Address of Facility
Fort Lincoln Funeral Home
3401 Bladensburg Rd., Brentwood, MD 21. Signature of Funeral Service Licensee eny 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiovascular Accident /Medical Due to (or as a consequence of): Examiner Perpheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): physician 68760 Physician/Medical the attending IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐ Pregnant at time of death 5 Other (specify) the detached o 9 Unknown 9 Unknow signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ pe Diabetes Mellitus 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autonsy perform certificate 2 No 1 ☐ Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 1 ☐ Yes 2X No Hospice this in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification: Division Hospital or Attending 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after deati To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 1⊠ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51639 October 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21626 609 Daffin Lane, Denton, MD Karen Moffett, M.D., . Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 6 2005 Registrar

DHMH 17 Rev 1/2001

Registrar

4 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) A.K.A. Stanley Hiatt Probst october Year **Physician** PROBST **11.**39 a[™] 13 2005 JOHN STANLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Memorial Hospital Frederick Frederick 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) 77 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours ^{Ye}1927 1**X** M 2□F Pennsylvania 218-76-4281 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itams 23a or 28a-f show The Medical Examinar must be notified at Frederick Frederick Maryland 1 Yes 2 □ No Directo 10e. Street and Number 355 Monteuve Lane 10g. Citizen of What Country? 10f. Zip Code 21702 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "na any injury or other traumatic event, Ira Music once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Driskill John Stanley Probst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Probst, brother 1723 Chartwell Trace, Stone Mountain, GA 30087 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Smithsburg Crematory Oct. 15, 2005 Smithsburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I Icensee ²²Keeneydand Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compli∉ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SPIN AL COMPRESSION COR D 10 D /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medicai as the l esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Cher (specify) 4☐Pregnant at time of death Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **≥** O STEO METHRITIS 1 Yes 2 No 3 Probably 4 Unknown SCHIZOPHEENIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 3 No 1 Yes 1 Tes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ♥Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident after death the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funaral Di

completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D21936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS JOHNSON DR FREDERICK 65C 4. DONELSON MD 31. Date filed (Month, Day, Year) 32. pegistrar's Signature State 0 2005 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 34044 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Allen Pancake OCTOBER 10TH, 2005

Examiner Funeral

1 - For State Registrar

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Exam or must be untitled at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

rsiclan and e burial-transit or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, the t nding pl esn nse for us ed by the detached Division of Vital After

death. Director: To the Hospital within 24 hours a To the Funeral I

3. Time of Death **Physician** 16:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month Day Year) Oct 1, 1925 7. Age (In vrs. last birthday) **™**M 2□F Yrs. 80 214-20-4754 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Allegany Cumberland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 510 Sheridan Place 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. No Yes 2 No No No Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Brakeman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James A. Pancake Lorraine (Clayton) Pancake ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Susanne Pancake daughter 510 Sheridan Place MD 21502 Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/14/2005 Flintstone Rocky Gap Veterans Cemetery MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced bladdel maily Due to (or as a consequence of): 03 Cella Cu pheral allesse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner disese Goon C Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 TYes 2 A No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 1 Yes 2 No 2 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14105 D60478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 KENT AVENUE, CUMBERLAND, MD 21502 AHMAD, AFAQ, M.D.,

State Registrar 31. Date filed (Month, Day, Year)

9 2005

32. Registrar's Signature'

TI FANY PERKINS 05-06816 RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Dhugiei		1 - For State Registramend Item 4. 1. Decedent's Name (First, Middle, Las	9	LUCIII L	50 920 7	and the ope	2000	Month	CLEATITY .			of Death
Physici /Medic			RKINS					Octobe		2005 ^{Year}		40 p.™
Examin	er	4a. Facility Name (If not institution, give			g.		r Location of Deat	h		. County of Death		
		Courtyard Marriot 5. Social Security Number 6. S		enton ge (In yrs. Ias		Silver If Under 1 Year		8. Date of B	of Birth (h. Day, Year) 9. Birthplace (State or Foreign Country)			o or Foreig
Funeral Director			DIA METE	27	Yrs.	Months Days	Hours Min.	(Month, D	7,19	78 Garl	and,	TX
/land		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside	City Limits
Man	to	Wash. DC		Wash	ington	, DC					1 🔀 Y€	es 2 No
th with the 23a or 284	al Direc	10e. Street and Number 134 R Street, NI	E			10f. Zip Code 20002			10g. Citizen of What Country? USA			
s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelih and Mental Hygiene. If the sith and Mental Hygiene. Other treumatic event, the Musical Examination into the modified at	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces? 1 Yes 2/1 If Yes, Give Year or Dates:	?	1	/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or N to Rican, etc.)	0-	14. Race - Amer Black, White Specify: B1		
72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced (Give I	ent's Usual Occup	ation during most of wor d)	rking	16b. K	ind of Business/l	Industry	
12 should be filled within h and Mental Hygiene. 7 is marked other then " reumatic event, the Mes.	dm	Elementary/Secondary (0-12)	College (1-4or	5+)		al Stude			Ном	ard Univ	arcit	W
dygie ther t	ပိ	17. Father's Name (First, Middle, Last)	4		rieurc	ar stude	18. Mother's Nar	ne (First Middl			EISIL	<u>y</u>
ontal l	Be c	Glenn Perkins					Gloria			ourname)		
mari mati	၉	19a. Informant's Name/Relationship (ype, Print)		19b. Mailin	Address (Street	and Number or Ru			or Town, State. Z	ip Code)	
eelth a n 27 is ner treu		Gloria Perkins/Mo	other				w Blvd. Dai					
Department of Heelth at Important: If item 27 is any injury or other treu	Ì	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	CAL	ce of Dispos netery, crem	ition (Name of atory or other place	ce)	Date	20c. Lo	ocation - City or 1	Town, State	
ment of I		4 ☐ Donation 5 ☐ Other (Specify)			n Cremator				andria, VA		
Departr Import any inj once.		21. Signature of Fyneral Service Licen	sed L	//-	22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746							
U = 6 Q	_	23a. Par 1. Enter the disease, or com	vou							20/46	Approxim	
Medical and and as the burial-transit	edical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as d.	s a conseque	nce of):							
the attendir hed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)	′			23d. Date of delin Month	very Day	Year
s been signed by should be detac	Ď	Part II. Other significant conditions of	ontributing to death t	out not result	ing in the un	derlying cause giv	en in Part I.		tobacco u	use contribute to		of death?
ate ha: paga 2	Completed							24a. Wa auto peri 1 X Yes	opsy omed?	death?	completion of	s available cause of
this certific ral director,	Be	25. Was case referred to medical examiner?				1-	26. Place of Dea	ath (Check only	one)			
this o	၉	XXYes 2 No	Hospital: 1 ☐ Inpati		R/Outpatient		4 🗀 ivui sirig r	lome 5 Res		6 Other (Spec	ity) At s	scene
ifter death. Director; After in by the fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 X Suicide 4 Homicide 5 Pending investigation could not be determined	28e. Place of In	ly Year)		P ^M 28c. Injur Wor 1 D eet, lactory, office	Yes 2 LNo	28f. Location City or To	inge (Street an	ested dr ad Number or Ru b) 8605 F ing, Md	ugs ral Route No enton	Stre
within 24 hours and the funeral I completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best niner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred at the tire estigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time	e cause(s) , date and) and manner as d place, and due	stated. to the cause	e(s)
To t	×	29b. Signature and title of certifier	hall mi			29c. Licens	e number CME			te signed (Month ber 7, 2)
			thall, mid			Print) 111 P	enn Stree	et Balı	imor	e, Mary	land 2	21201
Sta	te	31. Date liled (Month, Day, Year) OCT 1 2 201	32 Regist	rar'ş Signatu	re	-						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiefe 05 34046 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 2005 12:52 A ^M JAMES ALTON PROCTOR, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location ol Death 4c. County of Death Examiner CHARLES 2301 WOODBERRY DRIVE BRYANS ROAD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F AUGUST 8,1950 WASHINGTON, D.C. 212-54-5300 55 Director Usual Residence of Decedent Maryland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Exactions marker confitted at 1 ☐ Yes 2€ No Director MARYLAND CHARLES BRYANS ROAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20616 2301 WOODBERRY DRIVE UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 L No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4or 5+) 8TH GRADE MACHINE OPERATOR CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES ALTON PROCTOR, SR. SYLVIA CATHERINE ROBINSON PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum once. TYREESE C. PROCTOR/ DAUGHTER 2301 WOODBERRY DRIVE, BRYANS ROAD, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ST. JOSEPH'S CHURCH CEMETERY OCTOBER 6, 2005 POMFRET, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Servicence THORNION FUNERAL HOME, P.A LADIA C. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest iratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Ray Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical phys as anding I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ŏ Day 4□Pregnant at time of death 5 Other (specify) ned by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by sign be 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

31. Date filed (Month, Day, Year) OCT 0 4 2005

29b. Signature/and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DANTEL M. HOWELL, M.D. 11345 PEMBROOKE SQUARE, SUITE 104, WALDORF, MD 32. Regierar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** October 7, 11:45 ROULETTE William Franklin /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ravenwood Assisted Living Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
August 21,1921

8. Birthplece (State Country)

Maryland Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□ F 217-18-8750 84 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23e or 28e-f show ant: If item 27 is marked other than "natural", or other traumatic event, ite Musical Event at marker a calling a 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Washington Hagerstown 11☑Yes 2 No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1129 Luther Drive 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation. 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0-11 aircraft industry supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Samuel Patterson Roulette Leoda L. Eichelberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Roulette - wife 1129 Luther Drive, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete October 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o important: If any injury or once. Hagerstown Crematory 2005 * 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland 21. Signature of Fyneral Service Licensee Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 tred L. Vesters 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate 2 No 1 ☐ Yes 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes / 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 29c. License number 00056 no completed cause of death (Item 23a) (Type, Print) 30. Name and a 11110 MEDICAL CAMPUSRO. HAGERSTOWN MO 21742 31. Date filed (Month C 32. Pegistrar's Signature State 2005 Registrar

05-06 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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State of Maryland / Department of Health and Mental Hygieme 0 0 5	31,0
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			1- For 10-6-05 Registrar Amend # 27	State of Ma	co Cé	ertificate of	Death	Mental m	101010	005	34048	
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			1251 DAHLIA LANE			FREDER			FRI	EDERICK		
	Funeral		5. Social Security Number 6. S	ex 7.Age M∑M 2□F	(In yrs. last birthda)	y) If Under 1 Year Months Days			lirth Day, Year)	9. Birt	hplace (State or Foreign	
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	land ow		10a. State 10b. County		10c. City, Town or I	Location					10d. Inside City Limits	
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ב	ling Afte une	ion:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injun (Month, Day	Year) Injury	Wo	ry at ork?	28d. Describe	how injun	occurred		
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<u>≥</u>	교육	Certification:	4 ☑ Homicide determined	building, etc.	(Specify)	,		City or To	own, State,	1251 DAHLI	À CAME	
	Hospitel 24 hours e Funeral I		29a. Certifier 1 Certifying Ph	ysician: To the best o	5TV-C f my knowledge, dea	ath occurred at the t	ime, date and place	and due to the	e cause(s)	and manner as	stated.	
	To the Hospitel within 24 hours (To the Funeral completely filled	Medical	(Check only 2X Medical Example)	niner: On the basis of and manner stat	examination and/or	investigation, in my	opinion, death occu	arred at the time	e, date and	place, and due	to the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licen	se number		29d. Dat	e signed (Monti	n, Day, Year)	
)				N. IE		0.C.	M.E.		OCTO	BER 1,20	005	
R	(2)		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type							

State Registrar

OCT 0 6 2005

31. Date filed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signatu

O5-06694 WILLIE ROPER WHM

			For State	State of Maryl	and / Depa <i>Ce</i>	artment of <i>rtificate o</i>	Health and	l Mental Hy		5 34049
			Registrar 1. Decedent's Name (First, Middle, Last)		rineate o	Death	2. Date of De	Day V	3. Time of Death
	Physici /Medio		Willie Oliver Rope					OCTOBE	R 1, 2005	
	Examir	ıer	4a. Facility Name (If not institution, give PENTNSULA REGIONAL			4b. City, Town	i, or Location of De	ath	4c. County of WICOMI	
	Funeral		Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Ye	ar If Under 24 H			Birthplace (State or Foreign Country)
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary B-f sh	tor	MD Wicomio	co	Salisbu	ſУ				¥∑Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	eath w	erai	207 Stone Street 11. Marital Status	12. Was Decedent Ever	in U.S. 13	2180		(Specify Yes or No	U.S.	American Indian,
21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23a or 28a-f show other traumatic event, the Medical Evarinating trained to a collised at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify C	of Hispanic Origin? uban, Mexican, Pui No Specify:	erto Rican, etc.)	Black, Specify:B	White, etc.
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121	filed within Hygiene. other then	Jupi	Elementary/Secondary (0-12)	College (1-4or 5+)		clift Op			Process	ing Plant
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Maryland	d 2 sho th and 7 is mu trauma		19a. Informant's Name/Relationship (T) Dwayne Moore/ New				et and Number or St., Sal		er, City or Town, Sta	ite, Zip Code)
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ë	Pages nent of I ant: If its ury or o		1X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Mt. Calv	ary U.M	.c 10/	/8/2005	Fruitl	and, MD
Baltimore,	permit. Pages. Depertment of Himportant: If ite any injury or of once.		21. Signature of Final Savan con	3	2	2. Name and do	dress of Facility N. Watsor est Rd.	Funeral Salisbur	Home y, MD 218	01
ı			23a. Partt. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the cone cause on each line.	death. Do not en					Approximate Interval Between Onset and Death
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				W. /2		-	OCME		OCTOBER 2	2, 2005
			30. Name and address of person who d			Print) 111	Penn Str	eet Bal	timore, Ma	ryland 21201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Physistrar's S	ignature	<i>A</i>				
	Regist		OCT 0 4 2	005 Males	H. Le	perte				

05-06811 Smith, George

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year George Raymond SMITH /Medical October 6, 2005 0957 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11502 Dellwyn Drive Hagerstown Washington | Months | Days | Hours | Min. | Nov.28, 5. Social Security Number Funeral^{*} 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 1**X** M 2□ F Director 218-24-9516 75 1929 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23s or 28s-f shout the Madical Exactinar must be notified at 10d. Inside City Limits Directo Maryland Washington 1 ☐ Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11502 Dellwyn Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1⊠Yes 2□No If Yes, Give Year or Dates: Korean War 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced Specify: Specify: white Completed 72 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 technical illustrator aircraft is marked other 17. Father's Name (First, Middle, Last) 2 should be family and Mental F Be 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Smith Florence Brenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Janet M. Smith - wife 11502 Dellwyn Dr., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages ō <u>_</u> 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem.Park 10/11/05 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or corn, lication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Intraoral aunshot wound /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any locating to influed interest cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). nding physicien and use es the burial-translt The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical use es the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy ō ed by the a Pregnant at time of death Year 5 Other (specify) Day 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signe page 2 should be 1 ☐ Yes 2 🖏 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Scene Certification: To 1 XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA terel Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending seif 2 Accident investigation Oct 6,2005 9.20 1 Yes 2 No Subject shot 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel (Dellwyn D. 11502 Hagerstown, MD nome 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tashalflee MO OCME October 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha areenberg M.D 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) egistrar's Signature State 2005 1 Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland, Department of Health and Mental Hygiene 0 5 34051 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year october 1816 Philip Lee Shank 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 20, 1955 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country)
 Mary I and **Funeral** 1⊠M 2□F Director 220-64-1749 50 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23a or 28a-f ehow Examper a ust be natified at 1XX es 2 □ No Washington Maryland Williamsport Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death v and Mental Hygiene. ie marked other then "neturel", or iteme 23s 20 South Artizan St. 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify. 3 ☐ Widowed 4 X ivorced White Completed The Mudical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cardboard Box Manu. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be it. Peges 1 and 2 should be introduced to Mental Mental Items? If item 27 is marked o Samuel Theron Shank ပ Mary Ellen Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel T. Shank - Father 109 E. Sunset Avenue Williamsport, Maryland or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State ° 4 ☐ Donation 5 Other (Specify) Greenlawn Mem. Park Oct.12,2005 Williamsport, Maryland permit.
Dep.rtn
Importe
any nju 21. Signature of Juneral Service OSBUTTIE AT THE FAMILY HOME, P.A. 1425 S. Conococheague St.Williamsport,MD 21795 23a. P.11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HHouselevite **Physician** /Medical Examiner artus-Sequentiafly list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy performer 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 2 No this (funeral 28a. Date of Injury (Month, Day Year) Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature d title_of_certifier 29c. License number 29d. Date signed (Month, Day, Year) 10016965 porret KACH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fut Hazesta 32 gegistrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

2005

			1- State of Maryland	d / Depa	artment of H rtificate of L	ealth a Death	nd Me	ntal Hyg	giene Reg. No.	2005	34052
	Physicia	222	Decedent's Name (First, Middle, Last)				2.	Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		CHARLES H. STUR	GIS	JR.		ξ	Sept	26,		9:38 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Death		4c. C	County of Death	
			613 8th Street		Laure				Pr	ince G	eorge
	Funeral Director		5. Social Security Number 252-48-9140 6. Sex 72	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 3	Date of Birth (Month, Day Jan 1	5, T9	9. Birth Cou 33 GeC	place (State or Foreign ntry) Orgia
	and wo		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary f sh	ō	Ma Davin and Guarana	T.a	urel						1⊠Yes 2 No
	28a	rec	Md Prince George	Ба	10f. Zip Code				10g. Citize	en of What Cou	ntry?
	3a or		613 8th Street		2070	7				S.A.	,
	ms 2	era	11. Marital Status 12. Was Decedent Ever in U.S	6. 13.	Was Decedent of Hi f Yes, specify Cuba		in? (Specif	y Yes or No-		4. Race - Ameri	can Indian,
9	72 hours after death with the Maryland natural; or flams 23a or 28a-f show lical Exam is finus to incliffed at	교	1 Never Married XXMarried Armed Forces? 1 XY Yes 2 No If Yes, Give 5 2 1				Puerto Ric	an, etc.)		Black, White,	
င္ထ	rai', c	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 52—5	55	1 ☐ Yes 🏖 No	Ѕреспу:			8	Specify: Bl	.ack
21215-0036	72 h	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation furing most	of working		16b. Kind	d of Business/In	dustry
2	ithin nan Ma	μ	Elementary/Secondary (0·12) College (1-4or 5+)		kind of work done d DO NOT use retired,				TAT	CCC	
7	lygier her til	S	12th Grade	Ma	il Cle					SSC	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Interest or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examine must be notified at once.	To Be	17. Father's Name (First, Middle, Last) CHARLES H. STURGIS SR			M	IINNI		DBB		
, Mar	and 2 shi balth and 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) BEMLAH D. STURGIS (Wife)	19b. Mailir 613	ng Address <i>(Street</i> a						
ore	of He		20a. Method of Disposition 20b. Pl. 20b. Pl. 20b. Pl. 20c. Pl.	ace of Dispo	sition (Name of natory or other place	9)	Date	•	20c. Loca	ation - City or To	own, State
Ĕ	Pag ment		'4 Donation 5 Other (Specify) Md	Nati	onal Par	rk 10	/2/0	5	Lau	rel, M	d
Baltimore,	permit. Departi Import any inj		21. Signature of Funeral Service Licentee	S 22	Name and Address NOWDEN IS 46 N. Wa	s of Facility Tuner	al H	ome I	P.A.	20850	. Md
	験		23a. Part1. Enter the disease, or/complications that caused the death shock, or head failure. List only one cause on each line.	Do not ent	er the mode of dying	g, such as c	ardiac or re	spiratory arr	rest,	NV I I I C	Approximate Interval Between
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	/Medical		resulting in death) a. Due to (or as a consequ		176001	1	11/60				
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9	death certific e attending p id for use as	Mec	IF FEMALE:								
Вох	ath or	Physician/Med	23b. Was decedent pregnant in the past 12 months?	death 3	Ectopic pregnancy				23	ld. Date of delive Month	ery Day Year
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<u>s</u>	Attending r death. ector: After by the fune	cal	2 Accident investigation 3 Suicide 6 Could not be 389 Bloce of Injury. At hor	no form of		62 5 14		Location (C	troot and	Number of Dura	al Route Number.
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	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and file of certifier	1	29c. License	number		2	9d. Date	signed (Month,	Day, Year)
}	0		X/mm Od. /		V DI	713	5	(291	28/2	005
	8		30. Name and address of person who completed cause of death (Item	23a) (Type.	Print)		_		_ '	20/0	
			Lawrence R. Swink, MD 5450 KNO	1 Nov	th Dr. #1	20 G	olum	bia. N	1D 2	1045	
		te	31. Date filed (Month, Day, Year) OCT 06 2005 32. Egistrar's Signate							-	
	Sta	٠,									

		For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artment of F rtificate of	dealth and Death		Reg. No.	005	34053
Physic		Decedent's Name (First, Middle, La Stephen George					2. Date of De Month Octobe	Day	Year 2005	3. Time of Death 3:45 P M
/Medi Exami		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of De			County of Death	3.43 1
		Casey House	7.4.4		Rockvill		ro 0 = 1 = 1		ntgomery	
Funeral Director		051-44-4003	Sex 7. Age (In y	rs. last birthday 56 Yrs.	Months Days	Hours Mi		th ay, Year) 194	Coun	
land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Limits
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if the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Coun	itry?
eth w	Tag.	17117 King James			20877			USA		
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Important: if Item 27 Is marked other than "naturei", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinat must be institted and once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No		(Specify Yes or No erto Rican, etc.)	1	4. Race - Americ Black, White, o Specify: Whit	etc.
2 hou	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occup e kind of work done	pation		16b. Kin	nd of Business/Inc	
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Mental Mental rked of	To B	George Walter St	cach			Martha	Radich			
ind 2 sho alth and h 27 is ma		19a. Informant's Name/Relationship (Ralph Eshelman/Po			ing Address (Street 8 Prestor					Code)
Pages 1 a		20a. Method of Disposition 1 Burial 2 XCremation 3 4 Donation 5 Other (Specif	Removal from State	cemetery, cre	osition (Name of or other place) Crematory		tober 5, 2005		cation - City or To	
permit. Depenting		21. Signature of Funeral Service Licer	D1101-41		2. Name and Addre					
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the d	leath. Do not er	ter the mode of dyii	ng, such as cardi	ac or respiratory a	rrest,	IKSVIIIE	Approximate Intervat Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chronic Re		ease					Criser and Death
Examiner		Sequentially list conditions,	b. Advanced D	iabetes	Mellitus					
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The Coll d3, T.C. DOX 00100, The law requires that the deeth certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		2	3d. Date of delive Month	ory Day Year
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To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Proceedings (Check only one) Medical Example 1	miner: On the basis of exam and manner stated.	knowledge daw nination and/or ii	th occurred at the til nvestigation, in my o	me date and pla opinion, death oc	na, and due to the curred at the time,	date and	and mariner as all place, and due to	the cause(s)
To the within To the comp	Me	29b. Signature and title of certified			29c. Licens	se number		29d. Date	signed (Month, L	Day, Year)
12		Call	uc-		<u>U4</u>	1118		1e	103/0	25
)W		30. Name and address of person who Charles Harrison				Rockvi	11e, MD 2	20855		
St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 6	32. Figistrar's Si	ignature	back,					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item 20b per ffh 8850 13-13-05 Health and Mental Hygiene 55

34054 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:39 AM DeAndre Κ. Sykes 30 SEPT. 2005 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Agnes Health Care Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-17-1983 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours **½**M 2□ F 577-08-2891 Yrs. Washington. Director DC Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 ie marked other than "nature!", or frama 23e or 28e-f ehow treumstic event, the Medical Examiner must be nothing as DC Washington YOYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2829 Gainesville Street SE #203 20020 USA Pages 1 and 2 should be filed within 72 hours efter death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: 2 Specify:Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private Elementery/Secondary (0-12) College (1-4or 5+) Executive Assistant 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tyrone Young Sharon E. Sykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if item 27 ie eny injury or other treu pace. 2829 Gainesville St. SE #203 Washington, DC 20020 Sharon E. Sykes Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 10/06/05 Riverdale, MD 21. Signature of Funeral Service 22. Name and Address of Facility Bianchi 814 Upshur St NW, Washington, DC 20011 e, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Acquired immunudoficiency year **Examiner** Examiner seven months monary The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) DEANDRE Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 YNo 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 10 Yes 2□ No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 (Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No the f after deeth Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

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completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056143 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) PATHOLOGY ST. AGNES HOSPITAL, 900 CATON AVE. BALTIMORE
BEGISTER'S SIGNATURE W. RAYMOND ZHU Registrer's Signature 31. Date filed (Month, Day, Year) State OCT 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** Pearl Elizabeth Stombaugh October 14, 2005 4:10 PM M /Medical 4a. Facility Name (If not institution, give street and number)

Citizens Care and Rehabilitation Center 4b. City, Town, or Location of Death er Frederick 4c. County of Death Frederick Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth OCL. 8, 1910 5. Social Security Number 579-03-5808 7. Age (In yrs. last birthday) 95 Yrs. 6 Sex 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 KF Pennsylvania Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Example of most be notified at Frederick Maryland Frederick 1 X Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 110 Burgess Hill Way, Apt. 313B U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Specify: Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental H A.W. Speidel Frances E. Rouzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08 permit. Pages 1 and 2 Department of Heelth a Important: If itam 27 Is any injury or other tret <u>once</u>. Gladys R. Hadaway, niece 9137 Bassett Lane, New Port Ritchie, Fla. 34655 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 □ Cremation 3 □ Removal from State Green Lawn Cemetery Oct. 18, 2005 Roaring Springs, PA 4 ☐ Donation 5 ☐ Other (Specify) Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signature of Funeral Service Licensee M00255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or results shock, or heart failure. List only one clause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** seme /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9☐ Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 No 1 🗌 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2000 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: d in by the f 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours eff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and trile of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) October 17, 2005 1 80 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 200534056 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Wilson Swartz 2005 11:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Villa Rosa Nursing Home Mitchellville Prince George's 8. Date of Birth
(Month, Day, Year)
Jan. 14,1912 Pennsylvania If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 93 177-05-0899 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f show troumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director MD Prince George's Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3800 Lottsford Vista Road 20721 USA filed within 72 hours after death. Hygiene. Met then "natural", or Items 234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify 3 XWidowed 4 ☐ Divorced Year or Dates: WW II White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Service Technician Dictaphone Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental } Minnie May Osmun William Ambrose Swartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 12605 Hillmeade Station Dr. Stephen W. Swartz / Son Bowie, MD. 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State Pages 1 ment of F tant: If its 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depar ment of Important: If any injury or once. Fairfax Memorial Park 10/06/2005 Fairfax, VA. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PS disease or condition resulting in death) /Medical to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the 98 attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No o. 9 Unknown 9 Dunknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform certificate 1 Tes 2 🗌 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and ti le of certifi 29c. License number 29d. Date signed (Month, Day, Year) 226 10-4-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard J. Feldman, M.D. #A-4Lanham, MD. 9500 Annapolis Rd. 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Ce</i>	artmen <i>rtificati</i>	t of H e <i>of L</i>	ealth a D <i>eath</i>	and Me		giene Reg. No	000	34057	
		Q.	1. Decedent's Name (First, Middle	e, Last)							2. Date of De			3. Time of Death	
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	Funeral Director		5. Social Security Number 081–18–1813	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 82	Yrs.	Months	Days	If Under Hours	Min	B. Date of Bir (Month, Da Sept • 4	th i <i>y, Year)</i> 1 10	9. Bi	inthplace (State or Foreign Country) OKLYN, NY	
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Maryland	C1 44 70 0		19a. Informant's Name/Relations										or Town, State,		
	l and lealth im 27 ther tr		Lois Jane Schwe 20a. Method of Disposition	izer / sp	ouse	3302 Place of Dispo			escen	nt Dr.	-	-	is, MD.		
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Ba	permit. Departr Importe any inju		P R	Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home											
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8760,	ficate be executed physician and s the burial-transit	dicai Examiner	resoning in south, East	Due to	(or as a consec	quence of):									
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9 ×	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome of pregna	ancv							02d Date of d	liver.	
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	oirth 2 - Feta	al death 3	Ectopic pr						23d. Date of de Month	Day Year	
P.O.	the d	Jysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkn			3 0 0 (0)								
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п		on:	27. Manner of Death 1 ★Natural 5 □ Pendir	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f 2	8c. injury Work	at	28	d. Describe I	how injui	y occurred		
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Division	or At offer of Direct in by	E L	4 Homicide determ	singd 200. Flace	e of Injury - At h ing, etc. (Speci	iome, farm, sti fy)	reet, factory	, office		28	If. Location (S City or Tox			Rural Route Number,	
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	24 hos 24 hos Fun etely	Medical Certification:	(Check only 2 Medical one)	Examiner: On the b	asis of examination as a stated.	ation and/or in	vestigation.	in my op	oinion, dea	th occurred	at the time,	date and	and manner a I place, and du	e to the cause(s)	
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0	-111		30. Name and address of person	who completed cau			Print)				ANNA				
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<u>. </u>	Funeral	I	Frederick Memo: 5. Social Security Number 6	. Sex	7. Age (In yrs.			eder: 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th			(State or	Foreign
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ה ה	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23s or 28s-f ehow int, the Micilical Exat: it at must be collided at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usu kind of wo	al Occupa rk done d	ation <i>Juring m</i> os)	t of work	ing	16b. Kir	nd of Busines	s/Industr	у	
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5			1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	emetery, crer dar Hil				10/7	/2005	Sui	tland,	Mar	wlan	d
2	permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service Li		1						ch's Fu	inera	1 Home	, P.	A.	<u>u</u>
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			23a. Part1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final	omplications that c nly one cause on e	aused the deat ach line.	h. Do not ent	er the mod	le of dying	g, such as	cardiac (or respiratory a	rrest,		Inte	proximate erval Betw set and De	een
}	Physician /Medical		disease or condition resulting in death)	aDue to	cute or as a conseq	uence of):	e br	V Vc	23 CA	119	r 57	NI	se	1	Day	6
	Examiner	9	Sequentially list conditions	b											,	
-	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury													
	xecut	Examiner	that initiated events resulting in death) Last	c. Due to	or as a conseq	uence of):										
00/	certificate be executed ording physician and use as the burial-transit	ical	(d												
0	rtificat ng phy as the		IF FEMALE:													
X O	es that the death certifica igned by the attending ph be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?		irth 2 Feta	Ideath 3[Ectopic p					2	3d. Date of d	elivery Day	Ϋ́	ear
5	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregn 9☐Unkno	ant at time of down	leath 5	Other (s	oecify)					_	,		
ř.	law requires that the death as been signed by the atter 2 should be detached for u	by Ph	Part It. Other significant condition	s contributing to de	eath but not res	ulting in the u	nderlying (ause give	n in Part I		23e. Did t	obacco u	se contribute	to the ca	use of de	ath?
ecords,	w requires been sig should b										10	Yes 2	ZNo 3□1	Probably	4 □Ur	nknown
200	has be ge 2 sho	Completed									24a. Was	osy	24b. Were a	complet	indings a	vailable use of
	Pa ate										perfo 1 ☐ Yes	2 No	death1 1 ☐ Ye		No	
VII	sician: Th certificate irector, pag	o Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital:	Spections 2	ER/Outpatier		Othe	20		(Check only o					
5	€ = =		27. Manner of Death	28a. Date		28b. Time o		28c. Injury Work	4 🗆 146		me 5 Resident			өсігу)		-
VISION	Attending F death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investiga	tion	ii, Day 1 bai)	undry	М		Yes 2 🗌	No						
Š	or Attendition death	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of Injury - At h ng, etc. <i>(Specil</i>	ome, farm, sti (y)	eet, factor	y, office			28f. Location (City or Tox		Number or i	Pu <i>ral R</i> ou	ute Numb	Θ <i>Γ</i> ,
_	spitai or lours afte narai Dir filled in	al Ce	29a. Certifier Certifying	Physician: To the	best of my kno	owledge, deat	h occurred	at the tim	ne. date ar	nd place.	and due to the	cause(s)	and manner	as stated		
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	edical	(Check only 2 Medical E.	caminer: On the b	asis of examina ner stated.	ation and/or in	vestigation	, in my op	oinion, dea	th occurr	ed at the time,	date and	place, and de	ue to the	cause(s)	
	with To t	Σ	29b. Signature and title of certifier	(-)	1 1		29	c. License		٠			signed (Moi			
0	(2)			Shall	5 771	(en) .	mp		257	64	2	10	- 4-	05		
K	15)		30. Name and address of person w	ho completed caus	or death (tter	п 23а) (Туре,		08		Fr	3 eVen	ok	mn	d	170	12
3	Sta		31. Date filed (Month, Day, Year)	2. R	egistrar's Signa		20									
	Registr	rar	OCT 0 5 20	UJ /	W ST	1										

			State of Maryland / Department of Health and N	- 4	_000	34059
		3	1 Decedent's Name (First, Middle, Last) Registrar Amend item #22 Per DVR G84810 ifice #650 fire ath	Reg. N 2. Date of Death		3. Time of Death
eld.	Physicia /Medic	_	ELLEN BORDLEY SCHOTTLAND	SEPT. 3		
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHESTER RIVER HOSPITAL (ENTER CHESTERTO)	c. County of Dea KEN	
100	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign
er Mi	Director		218 /6 7/84 1 M 2 KF 83 Yrs. Months Days Hours Min.	MARCH 14	1722	"MD
	iryland thow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Ma	ecto	MD KENT CHESTERTOWN 106. Street and Number 107. Zip Code	100.0	itizen of What C	1 ☐ Yes 2 No
	3a or	al Dir	7989 QUAKER NECK ROAD 21620	109. 0	U.	S.A.
	tems 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerton Company Cuban, Mexican, Puerton Cuban, Pue	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
036	be filed within 72 hours after death with the Maryland tal Hygiene d other than *natural', or items 23a or 28a-f show svent, fra Medical Examinar count be calified at	þ	1 □ Never Married 2 Married 1 □ Yes 2 No 1 □ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: 1	LHITE
5-0036	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	16b.	Kind of Business	/Industry
212	filed within Hygiene. other then ent, the Me	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		HOUSE	WIFE
and	al Hyg al other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maide		
	should be ind Mental is marked o	မ	CARL NICHOLAS BORDLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	uTH	BAX or Town State	
Mary	nd 2 lith a 27 ls		STANLEY A. SCHOTTLAND THE TERTOUN MD	K ROAD 21620	or rown, state,	Σίρ C00θ)
ltimore,	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Location - City or	Town, State 2/620
Ē	tmen tant: njury		1. Signature of Fyneral Service Licensee MOOLZS 22. Name and Address of Fa	7/05 WILLIAMS	ESTERT	RVICE
Ba	permii Depar Impoi sny ir once.		Marin V. Welle S CHESTERTOWN	EN WAY	20 ,	
	· .		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Me. La 5. Latic Breeze resulting in death)	st ca		Onset and Death
3	Examiner		Due to (or as a consequence of): Sequentially list conditions			9
	ed sit	lner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
<u>,</u>	execution and ial-tran	Examiner	resulting in death) Last C. Due to (or as a consequence of):			
58760	ificate be executed g physicien and as the burial-transit	edical	d			
_	certifica ding ph se as ti		IF FEMALE: 23c. If yes, outcome of pregnancy		024 Date of de	line.
Вох	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	230. Was decement pregnant in the past 12 months? 1		23d. Date of de Month	Day Year
Р. О.	res that the de signed by the a be detached t	Phys	9 ☐ Unknown	00. 000		
	signed d be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?
COL	s been signature	olete		24a. Was an	24b. Were a	utopsy findings available completion of cause of
Division of Vital Records,	The lav	Completed		autopsy performed? 1 ☐ Yes 2 ☐ N	death?	completion of cause of 2 No
Vita	sician: Th certificate rector, pag	Be	examiner? Hospital:	th (Check only one)		
o	Attending Physician: r death. sctor: After this certifica by the funeral director, p	n: To	27. Manuar of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in		cify)
sior	eath. or: Alt	ertification:	2 Accident investigation M 1 Yes 2 No			
DIVI	after d Direct	ertifi	3 Suicide de mined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street : City or Town, Sta	an <i>d Number or R</i> te)	ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the cause	s) and manner a	s stated.
	the H thin 24 the F implete	Medi	29b. Signature and title of certifier 29c. License number		ate signed (Moni	
)	F 3 F 8		D365 4	/	0.3.0	5
	6-5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	dertain		
	Sta	10	PATRICK 5 Standard HD 120 See ROBIJS Che 31. Date filed (Month, Day, Year) OCT 0 3 2005 See ROBIJS Che Aparth	stertown	MD 21	190
	Registi		OCT 0 3 2005 Bleen & South			
	MH 17 Rev 1/2					

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

OCT 0 5 2005

JAY H. CHOI, M.D. 31. Date filed (Month, Day, Year)

30. Name address of person who completed cause of death (Item 23a) (Type, Print)

819 E. CAPITAL ST. SE 2. Registrar's Signature

OCTOBER 04, 2005

WASHINGTON, DC 20003

State of Maryland / Department of Health and Mental Hygien 6 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month (ear Mary Elizabeth TRIMBLE 6, 13:45 **Physician** October 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington Hagerstown 10108 Sharpsburg Pike If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 23,1919 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours να. W. Yrs. 86 219-36-3806 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be liled within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow ary or other traumatic avent, the Medical Examinations to buildhad at 10c. City, Town or Location 10a State 1 ☐ Yes 2X No Hagerstown Washington Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 10108 Sharpsburg Pike Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) public school system teacher 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Viola Lee Hudgins Frank Staley Trimble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 155 Chance Lane, Kearneysville, W.Va. 25430 Martha M. Crouse - niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory 10/8/05 permit. Page Department of Important: If any injury of * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Approximate Interval Between Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Due to (or as a Examiner certificate be executed and Due to (or as burial-Box 68760, attending physicien Physician/Medical the 88 IF FEMALE: 951 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? õ 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No P.0. the 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be þ Division of Vital Records, 2100 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 DN Hospital or Attanding Physician: 26. Place of Death (Check on Be 25. Was case referred to medical examiner? director Hospital: 1 Inpatient Other: 4 Nursing Home 5 sidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Yes this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deatl
To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chec the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 10 D0022043 0 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Dwight Wooster, M.D., 11110 Medical Campus Rd., Hagerstown, Md. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Baltimore,

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 🏚 🕦 🖯 5 34062 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10:37AM harle homas October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 102M 2□ F Months Days Hours 216-32-0 Director Oct. 10,1932 Maryland Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or Items 23a or 28a-f show sumatic event, the Medical Examinar mater by molified at 1 Yes 2 No Director T. More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3406 1215 Hvenue Was Decedent Ever in U.S. Armed Forces?

1 DYes 2 No 1952
If Yes, Give
Year or Dates: 1954 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No ģ Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Natural Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be ealth and Mental Sam Thomas Novella (sale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other traugnos. 20b. Place of Disposition (Name of Date cemetery, crematory or other place) brenda Dover Delaware 19901
20c. Location - City or Town, State EMORY Baltimore. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7 05 4 □ Donation 5 □ Other (Specify) 10 Ve teran's Cemetery Hurlock, Maryland 22. Name and Address 1 Facility HENRY FUNERAL HOME, 21. Signature of Funeral Service Licensee 23a. Park! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 510 Washington St Cambridge, Maryland 21613 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Heart Failure /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of ypertension use as the burial-transit The law requires that tha death certificate be executed and Due to (or as a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Whiknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has t lirector, page 2 s 1 Yes 2 000 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examinor Hospital: Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Thomicide Medical 29a, Certifier

O of Vital within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. To the Hospital

HOMES

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 10054482 October 3,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West Belvedere Ave Baltimore, MO21215 McGinley T m.D.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature 2005

Physician /Medical Examiner

Funeral Director

28a-f ahow the Medical Examiner must be notified at Нете 23а ö natural',

RONAL

AYLOR

Director

certificete be executad as the burial-transit Box 68760. physician attending use detached for o ۵ Records, has certificete of Vital filled in by the funeral director. After Division daath or Attend after death Director:

Funeral \$ Completed Maryland 2121 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Be 2 permit. Pages 1 and 2: Dapartment of Health ar Important: if Item 27 is any injury or other trauging. Baltimore. **Physician** /Medical Examiner Examine Physician/Medical signed by ۵ Completed 25. Was case referred to medical Be 27. Manner of Death Certification: To the Hospital within 24 hours a To the Funeral Completely filled in 29a, Certifier Medical 29b. Signature and title of certifier

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Charles Taylor Scotember 29 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 ☐ F Yrs. 72 Nov. 28, 376-32-2221 1932 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6100 Westchester Park Drive - Apt. 1812 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) National Science Elementary/Secondary (0-12) College (1-4or 5+) 5+ Doctor (PHD) Foundation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Percy Taylor Blanche Virgo 19a. Informant's Name/Relationship (Type, Print)

Domestic Partner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 Westchester Park Drive #1812, College Park, MD 20740 Ming-Ying Wei **Spouse** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/04/2005 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Constance ase 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Infarction Myocardia Due to (dr as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unkhown 1 Des 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an

26. Place of Death Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number D0042687

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

2 2 No

28d. Describe how injury occurred

1 ☐ Yes

34063

3. Time of Death

Birthplace (State or Foreign
Country)

10d. Inside City Limits

Approximate Interval Between

Onset and Death

nun

Year

Day

1□Yes 2☑No

3 Probably 4 Unknown

1 X Yes 2 No

Michigan

Black White etc.

2005

8:15 PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- Turly I, M.D.

Doctor's Community Hospital, 8118 Good Luck Road, Lanham, MD 20706 Jay Zwally II, M.D.

31. Date filed (Month, Day, Year) State OCT 0 5 2005

examiner'

1 Natural

2 Accident

3 Suicide

4 | Homicide

(Check only one)

1 ☐ Yes 2 ☑ No

5 Pending

investigation

6 Could not be determined

Registrar

			1 - For State Registrar	State of	f Maryland /		artment of H tificate of L		nd Ment		iene g. No.	05	340	64
	5 1		1. Decedent's Name (First, Middle,	Last)		-				ate of Death	n		3. Time of	Death
	Physici /Medi		Carroll H. Ut	z					o T	onth ·	02	2005	11:10	a^{M}
	Examir		4a. Facility Name (If not institution,	-			4b. City, Town, or					unty of Dea		
			Westminster Nur					inster			Carroll			
П	Funeral Director		5. Social Security Number 213-05-4303	6. Sex 1 ⊈M 2□F	7. Age (In yrs. last b 93	Yrs.	If Under 1 Year Months Days		Min. (M	ite of Birth lonth, Day, Irch	Year) 3 191	00	thplace (State of ountry) MD	
	ס		Usual Residence of Decedent										<u></u>	
	arylar show	-	10a. State 10b. County MD Car	rol1	10c. City, Tov		minster						10d. Inside Ci	•
	the M	Director	10e. Street and Number				10f. Zip Code		·	40	0'''		1 Tes	2 A 140
	with Ba or						211	57		,	Og. Citizen of What Country? USA			
	ter death	Funeral	1310 Washingto	12. Was Dece	dent Ever in U.S.	13.1	Vas Decedent of His Yes, specify Cubar		n? (Specify Y	es or No-			erican Indian,	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or Items 23a or 28a-f show event, if a Medical Evarifier must be notified at	by	1 Never Married 2 X Marrie 3 Widowed 4 Divorced	Armed For ed 1 XYes If Yes, Giv Year or Da	2 □ No e	1	Yes, specify Cubai	n, Mexican, P Specify:	Puèrto Rican,	etc.)	Sp	Black, White Pecify: W	hite	
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7	d 2 should the and Men 7 Is marked traumatic	J.	19a. Informant's Name/Relationsh	ip (Type, Print)	19	b. Mailin	g Address (Street a					own State	Zin Code)	
			Edward Utz/son				tarboard							
altimore,	~ ~ # # =		20a. Method of Disposition	. T	20b. Place o	of Dispo	sition (Name of natory or other place	1 1/	0/0572	005 2	Oc. Locat	ion - City or	Town, State	
<u>Ĕ</u>	artment of h crtant: If its Injury or of		1 □ Furial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		State i	-	n Memoria		dens		Fin	ksburg	J, MD	
Balt	permit. Pag Depurtment Important: I any Injury o		21. Signature of Funeral Service L	icensee			itts fün 12 Washin						21157	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cannot one cause on ea	aused the death. Do							27 1115	Approximate Interval Bets	9
뺼	Physician		Immediate Cause (Final disease or condition							Onset and D	Death EARS			
	/Medical Examiner		resulting in death)	Due to (or as a consequence	,							SAT	-7710
	- Adminior	e.	Sequentially list conditions,	b. Due to /	or as a consequence		111					-	6 WES	15
	uted d ansit	nju	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	500 (0)	or as a consequence	ol).								
Ć,	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (d	or as a consequence	of):							<u>_</u>	
8760,	cate be physicia the bur	dlcai		d										
9		0	IF FEMALE:								-87			
Вох	eath certifi attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?		come of pregnancy rth 2 Fetal deatl	h 3□	Ectopic pregnancy				23d	Date of del	*	·
0.	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of death wn	5 🗀	Other (specify)					Month	Day Y	'ear
4	that the od by detac		Part II. Dther significant condition	s contributing to de	ath but not resulting	in the ur	deriving cause give	n in Part I.	23	Be. Did toba	acco use	contribute to	the cause of de	eath?
Records,	quires n sign ald be	d by								1 🗆 Yes			obably 4 🗆 U	
00	aw requas been 2 should	Completed							24	a. Was an	2	4b. Were au	topsy findings a	vailable
Be	The lavate has	mo						-		autopsy		prior to death? 1 ☐ Yes	completion of ca	use of
Vital		BeC	25. Was case referred to medical examiner?					26. Place of	Death Ched	-		1 103	21,140	
of V	dis di	2	1 Yes 2 No	Hospital: 1 ☐ Ir	npatient 2 ER/O	utpatien	3 □ DOA Othe	Nursir	ng Home 5	Residen	ice 6 🗆	Other (Spec	cify)	
D C		on:	27. Manner of Death 1 ○ Natural 5 □ Pending	28a. Date o (Month		Time of Injury	28c. Injury Work	?		escribe how	v injury od	curred		
sio	ten eat or: the	cat	2 Accident investiga 3 Suicide 6 Could no	at he	of laive. At home 6			es 2 □ No			/ 4/		10	
Division	or Attendate death Director:	Certification:	4 ☐ Homicide determin	ned 286. Place buildin	of Injury - At home, fa ig, etc. (Specify)	am, stre	et, factory, office		Zer. Lo	ty or Town,	State)	umber or Hu	iral Route Numt	oer,
	Hospita 4 hours Funeral	edical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the xaminer: On the ba and mann	best of my knowledg sis of examination ar	je, death nd/or inv	occurred at the time estigation, in my opi	e, date and p inion, death o	place, and du occurred at th	e to the cau	use(s) and	d manner as ce, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifie	- 11	1- 1-	2	29c. License	number		290	d. Date si	gned (Monti	Day, Year)	
	MST		> That	CIY	M	0	Doos	955	-2		10	13/	tor 5	
	Mar		30. Name and address of person w	no completed cause				^	0		/		21	157
			VOURISIAN	MAR (An	mg 70	WA,	POOL,	EKL) (s	ESTM	NSTERI	m)
	Sta Registi	_	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signature	L	1							
	ricgisti	ai	OCT 0	3 2005	House D	1	parte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 23a per dvr 8848 10-19-05 vt. State of Maryland / Department of Health and Mental Hygiere 05 For State Registrar Amended item #23a per dr/wichartificate of Death 10-6-05/dls Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:45 FX /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15BUK 45TAL If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 126M 2□F Hours 220-28-174 Usual Residence of Decedent Director deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MB SALISBUR WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 USA 1801 OURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Folges: 1 Payes 2 No 1 Yes, Give Year or Dates: A R MY 1≥Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED permit. Pages 1 and 2 should be filed w Depertment of Heelth end Mental Hygier Important: if Item 27 is marked other it: any injury or other traumatic event, tha once. 10点 LABDRER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VANGIESON DORA JENKINS HAMPION 19a. Informant's Name/Relationship (Type, Print) DAUCHTER 320-A FORTON

20b. Place of Disposition (Name of cemetery, crematory or other place) 19b. Mailing Add ess (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHIADELPHIA PHI 20c. Location - City of Town, State Method of Disposition Date Burial 2 Cremation 3 Removal from State HURLOCK 4 □ Donation 5 □ Other (Specify) EMETARY (0 BENNIE SMITH FIH 21. Signature of Funeral Service Licenses 22. Name and Address of Ficility I SABELLA W nine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Metastatic Imp. Cancer Approximate Interval Betw Metastatic Lung Cancer 4 months Immediate Cause (Final disease or condition resulting in death) Physician YRAA /Medical **Examiner** Metastatic Lung Gancer 4 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 as the ettending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) be detached 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icete hes been sig r, page 2 should b 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes autopsy performed 1 ☐ Yes 2 XNo 1 ☐ Yes 2 💢 No or Attending Physicien: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 □ Nursing Home 5 □ Residence 6 × ther (Specify) + CSPICR_ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural Accident Injury 5 Pending death. 1 Tes 2 No investigation the within 24 hours efter death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058410 IK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waris DWWDDD 26266 31. Date filed (Month, Day 32. F gistrar's Signature Registrar

		•	For State Registrar	State of Maryland		tment of H			iene g. 7005	34066
*	1		Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death
	hysicia /Medic		Durwood	Lee	ŁW .	lley		October	9, 2005	5:53 p M
(2) (20) (3)	xamin		4a. Facility Name (If not institution, give st		4	b. City, Town, or	r Location of Deat	h	4c. County of	
	x _ %		13645 Evergreen Es		- 4 bint d \	Ridge	If Under 24 Hrs	O Data of Birth		. Mary's
	neral ector		237-26-1140	7. Age (In yrs. Ia 83		Months Days	Hours Min.	8. Date of Birth (Month, Day)		D. Birthplace (State or Foreign Country) Virginia
land	A 11		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	tion				10d. Inside City Limits
Mary	fied	ţō	Maryland St. Ma	rv's	Ridge					1 ☐ Yes 2★☐ No
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ath wi	dian.		13645 Evergreen E	states Lane		206	80		USA	
0036 hours after death with the Maryland	ie marked other then 'naturas, or tieme 238 or 28e-1 enow aumatic event, the Medical Examiner mast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3. Widowed 4 Divorced	 Was Decedent Ever in U.S Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates: 	If Y	s Decedent of Hes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
21215-0036 d within 72 hours af giene.	CHE	ted	15. Decedent's Educ	ation	16a. Deceder	nt's Usual Occup	ation		16b. Kind of Busin	ness/Industry
1215- within 72 ene.	Media	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	nd of work done of NOT use retired	during most of wo d)	rking		
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hould d Mer	narke	10	William B. 19a, Informant's Name/Relationship (Type	Wiley	10h Mailing	Addrson /Street	Ada		inson	ata 7'- Cartal
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Itimore,	y or		1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State		tory or other place I-Echols		4/2005	Charlott	e HAll, MD
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Heelth and Menta	importar eny injur once.		21. Signature of Funeral Service Ligense	A marin	22. N	Vame and Addre	ss of Facility d Funera	_		, MD 20650
s. 3	. <u>1</u>		23a. Part1. Enter the disease, or comples shock, or heart failure. List only on	cations that caused the death.						Approximate
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/Me	dical		disease or condition resulting in death)	Due to (of as a conseque	ence of):	earo	Parlur			
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8760, cate be executed	physicien and the burial-transit		resuming in dealing East	Due to (or as a conseque	ence of):					
	physi the t	dlcal	d							
	ව ස		IF FEMALE:	3c. If yes, outcome of pregnan	icy				23d. Date	of delivery
Vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certify redeath.	is certificate has been signed by the attendir director, page 2 should be detached for use	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 ⊟E	ctopic pregnancy other (specify)	/		Month	•
o e	by the achec	hysi	9 Unknown	9□ Unknown						
Division of Vital Records, P.O. to a National Physician: The law requires that the differ death.	gned l	y P	Part II. Other significant conditions con	tributing to death but not resul	iting in the und	erlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ord:	en sig		Montie Valve	Leplacer	non (1 □ Y	s 2 □ No 3	☐ Probably 4 ☐ Unknown
BCC	as be 2 sh	Completed	Coronary Art	Ley Dreas	·			24a. Was a autops	n 24b. We	re autopsy findings available or to completion of cause of
۳ ۽	ate h page	Som	, , ,	1	_			perfor	med? dea	ath? Yes 2□ No
/ita	entitio actor,	Be	25. Was case referred to medical examiner?		W W	100		ath Check only or	16)	
of o	this o	မှ	1 Tes 2540		R/Outpatient	3□ DOA Oth	4 Nursing i	lome 5 Reside		
Ling F	After	o	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2∐No	28d. Describe hi	ow injury occurred	
Division or Attendated death	ctor: y the	llcat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	ne, farm, stree			28f. Location (S	treet and Number	or Rural Route Number.
Div affer	d in b	Certification:	4 ☐ Homicide determined	building, etc. (Specify))	i, idotory, ombo		City or Town		or reservices to meet,
To the Hospital or within 24 hours after	To the Funeral Director: Atter th completely filled in by the funeral	edical C	29a. Certifier 1 ertifying Phys	ician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death o on and/or inve	occurred at the tir stigation, in my o	me, date and place	e, and due to the curred at the time, d	ause(s) and mann ate and place, and	ner as stated. d due to the cause(s)
To the within 2	To th	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Month, Day, Year)
- > 1	0		· ARA	MAD		D56	2-6-1		10/10	100
		A	30. Name and address a rson who con		23a) (Type, Pr	int)		1 1/2		
			Archana Gupta, M			enter,	HOTTAMOO	d, Maryla	ına 20636	
F	Sta Registi	-	31. Date filed (Month, Day, Year) OCT 11 20	32 legistrar's Signat		de la				

			1 - For State Registrar	State o	of Maryla		artmeni rtificate			nd Me		giezen ()	5	34067	
	Physici	1. Decedent's Name (First, Middle, Last)										2. Date of Death Month September 30,2005 3. Time of 10:45			
	/Medic		Haihuan Wu											10:45 A M	
	Examin	er	4a. Facility Name (If not institution, s Suburban Hospi		imber)		4b. City, Town, or Location of Death Bethesda				4c. County				
		-	•	. Sex	7. Age (In yrs	(ast birthday)	If Under				Date of Bird	Montg		y place (State or Foreign	
	Funeral Director		090-64-9704	1□M 2 X 1F	85		Months Days Hours Min.		Min.	(Month, Da larch	th y, Year) 24,1920	Chi	ntry)		
	ס		Usual Residence of Decedent									.,,			
	arylar show	_	10a. State 10b. County			ity, Town or Lo								10d. Inside City Limits	
	ha M.	ecto	Md. Montgo	mery		Bethesd							1 ☐ Yes 2 X No		
	with t	Funeral Director	10250 Westlake	Drive #	507		10f. Zip Code 20817					10g. Citizen of What Country? United States			
	death	era	11. Marital Status		edent Ever in U.S. 13. Was Decedent of H			ent of His	Hispanic Origin? (Specify Yes or No- pan, Mexican, Puerto Rican, etc.)				can Indian,		
9	aftar or itar		1 Never Married 2 Married		2 🗙 No					Puerto Rio	can, etc.)	1	k, White,	etc.	
903	ural',	d by	3 Widowed 4 Divorced	If Yes, Gi Year or E	Dates:		1 ☐ Yes 2	ZIAJ No	Specify:			Specify.	As	Lan	
5-	"natu	Completed	15. Decedent's (Specify only highest			(Give	dent's Usua kind of wor	k done du	ion <i>iring m</i> ost o	f working		16b. Kind of Bu	siness/In	ndustry	
12	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Teac	DO NOTus her	ө гөшгөа)				Public	Sch	0015	
р П			17. Father's Name (First, Middle, La	ist)		Teac			18. Mother's	s Name (F	First, Middle,	Maiden Sumam		0015	
an		To Be	Yang Yao Wu						Yee N	Veng	Wang				
Maryland 21215-0036			19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street ar	nd Number (or Rural F	Route Numbe	er, City or Town,	or Town, State, Zip Code)		
				Son)	9319 Elgir					eder	ick, N	1d. 2170	. 21704		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from	State 20b.	Place of Dispo cemetery, crer	sition (Nam natory or ot	e of her place,	00	t. 8	9	20c. Location -			
ţ	t. Pactiment:		`4 ☐Donation 5 ☐ Other (Spe	cify)	Pa	rklawn				2005		Rockvil	-	Md.	
Bal	parmii Dapar Impor any ir		21. Signature of Funeral Service Li	censere Du	1	10	Name and East	d Address t Dee	of Facility er Par	DeVo k Dr	1 Fune . Gait	eral Hom hersbur	e g, M	d. 20877	
П	J. L.		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that may one cause on	caused the dea each line.	th. Do not ent	er the mode	of dying,	such as ca	ırdiac or r	espiratory ar	rest,		Approximate Interval Between	
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0	he da the s	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	4∐Pregi 9☐ Unkn	nant at time of own	death 5L	Other (spe	ecity)						,	
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rds,	quiras in sign		Pneumonia			·					1 🗆 Y	es 2 X No	3 🗌 Prot	pably 4 DUnknown	
Record	aw raquii s baan s 2 should	plet									24a. Was	an 24b. W	/ere auto	psy findings available	
	: Tha law cata has l	Completed										med? de	rior to coi eath? □ Yes	mpletion of cause of	
Vital	ysician: Th is certificata diractor, pag	BeC	25. Was case referred to medical examiner?						26. Place of	Death (C	Check only o			ZEJ IVO	
of <	9 10 =	일	1 ☐ Yes 2 X No			ER/Outpatien	t 3 🗆 DO	A Other	4 🗌 Nursi	ng Home	5 🗆 Resid	lence 6 Othe	r (Specif	y)	
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isic	Attending r death. actor: Aftai by the fune	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be Occ Blood	of Injune - At h	lomo form at-	M		s 2 No		Location (C	Name and the section	and Diver	I Douba Marchae	
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_	a Hospital or Attent 24 hours aftar deatl 5 Funaral Diractor: ataly fillad in by tha		29a. Certifier 1X Certifying	Physician: To the	e best of my kn	owledge, death	occurred a	at the time	, date and c	olace, and	I due to the d	ause(s) and man	ner as s	tated.	
	To the Hospital or Attanwithin 24 hours aftar deati To the Funaral Diractor: complataly filled in by tha	edical	(Check only 2 Medical Ex	aminer: On the b	asis of examination of stated.	ation and/or inv	estigation,	in my opir	nion, death	occurred	at the time, o	date and place, a	nd due to	the cause(s)	
	within 2-	×	29b. Signature and title of certifier	A			29c.	License i)	2	29d. Date signed	(Month,	Day, Year)	
)	3		fill la	Colles	non	00	1) 2	5/7	10		October	3,	2005	
			30. Name and address of person wt Dr. Gita Bakshi					24	Rethe	sda	Md. 2	0814			
			31. Date filed (Month, Day, Year)						Decile	Juas	114 - 2				
	Sta Registr	_		2005	Registrar's Sign	y Alon	ME								

of Maryland / Department of Health and Certificate of Death	Mental Hygiene 005	34068
	2. Date of Death	3. Time of Death

5. P	1. Decedent's Name (First, Middle, Last)
Physician /Medical	NANCY
Examiner	4a. Facility Name (If not institution, give s
	HOLA CAUGE HUG

\$21	Physici /Medi			NANC	y J.	WALL				OCT.	5, 20	Year 05	10:22 A ^M		
	Examir		4a. Facility Name (If	not institution,	give street and nu	mber)		4b. City, Town, or	Location of Deat	1	4c. County of Death				
	*		HOLY	CROSS	HOSPITAL				ER SPRIN		MON	TGOME	ERY		
116	Funeral Director		5. Social Security No. 248-62-5		6. Sex 1 ☐ M 2 X F	7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JUNE 19	Year)		lace (State or Foreign try) TH CAROLINA		
	pug *		Usual Residence of 10a. State	Decedent 10b. County		10c City	, Town or Lo	cation				1	Od Inside City Limite		
	ahow	5				100. 0119			_		10d. fnside City Limits 1 1 1 1 1 1 1 1 1 1 1				
	the M 28a-f	Director	SC 10e. Street and Nun		ANBURG		SI	PARTANBUR 10f. Zip Code	G		0g. Citizen of V	Albet Coun	21		
	with	۵			, mann								try r		
	ne 23s	Funeral	11. Marital Status	WINDROW		as Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec				pecify Yes or No-	U.S	e - Americ	an Indian.		
336	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or Iteme 23a or 28a-f ahow other than "natural", or Iteme 23a or 28a-f ahow event, the Medical Examinar must be notified at	by Fur	1 Never Marri		ed 1 ☐ Yes If Yes, Gi	Armed Forces? If Yes 1 ☐ Yes 2 ☐ Thoughton If Yes			es, specify Cuban, Mexican, Puerto Rican, etc.)			ck, White,	etc.		
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212	i within jiene. r than	Eo	Efementary/Secon	ndary (0-12)	College (1-4or 5+)		SALES			RETAIL				
	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the Mi	0	17. Father's Name (First, Middle, L	ast)	,			18. Mother's Nar	ne (First, Middle,	o, Maiden Surname)				
ılar	Mental Mental Marked o	To B		OTTO	WILKE	RSON			C	ARRINE	PYE				
Maryland	and Nema		19a. fnformant's Na	me/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Street a	and Number or Ru	ral Route Number	, City or Town,	State, Zip	Code)		
	and 2 palth n 27 I		LYNNE	FLEMING	/DAUGHTE	R	42602	2 CLOVER	HILL RD.	, HOLLYW	OOD, MD	. 206	i 36		
ore	いまる動		20a. Method of Disp		3 □Removal from			sition (Name of natory or other plac	(0)	Date	20c. Location -	City or To	wn, State		
Ĕ	Pag ment ant: I		4 Donation				D SHEI	PHERD CEM	. 10-8	-2005	BOILIN	G SPF	INGS, SC.		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 le marked any injuryor other traumatic evonce.		21. Signature of Fu	neral Service L	MM/LL	LOW MOO	0091 58	Name and Address F BOL CLEVE	SS OF FACILITY UNERAL H	OME & CR	EMATORI	UM,P,	A. 737		
			23a. Part1. Enter th	ne disease, or o	complications that	caused the death						D. 20	Approximate		
	Physician		Immediate Cause (Final	only one cause on								Interval Between Onset and Death		
Kat.	/Medical		disease or condition resulting in death)	n	a	(or as a consequ									
	Examiner					IRATORY		RE.							
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oʻ	be executed sician and burial-transit		resulting in death) L	ast	Due to	(or as a consequ	uence of):								
68760,	ate br	Ica			d										
O. Box 6	he death certificate be executed the ettending physician and shed for use as the burial-transit	ysician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	1 Live	itcome of pregnal birth 2 Fetal nant at time of de nown	death 3	Ectopic pregnancy			23d. Dal Mo	te of defive	ry Day Year		
σ.	res that the signed by t I be detach	P.	Part II. Other signif	icant condition	s contributing to d	leath but not resu	ulting in the ur	ndertving cause give	en in Part I.	23e. Did tol	pacco use conti	ribute to th	e cause of death?		
Records,	law requires that the sas been signed by 2 should be detact	d by					· ·	, ,			s 2□No		ably 4 🖫 Unknown		
S	w requir been si should	lete								24a. Was a	24h 1				
Re	0 5 0	Completed								autops	V C	orior to con death?	osy findings available npletion of cause of		
Vital		ပိ	25. Was case refer	red to medical					00 Bloom (D)			I □ Yes	2 No		
5	Physician: this certifical	ToB	examiner?		Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	ar	ith (Check only on		/C t			
o			27. Manner of Death		28a. Date	of fnjury	28b. Time of	28c. Injury Work		ome 5 Reside			7		
Division		Certification:	1 Natural 2 Accident	5 Pending investiga		nth, Day Year)	Injury		k? Yes 2 □No						
Vis	l or Attendi after death. Director: A I in by the fu	HIC	3 Suicide 4 Homicide	6 Could no determin	ned 288. Place	e of Injury - At ho ling, etc. (Specify	me, farm, str	eet, factory, office 28f. Local			cation (Street and Number or Rural Route Number,				
ã	s afte	Cert			Dulid	ing, atc. (Spacing	′/			City or Town	i, State)				
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the examiner: On the to and man	e best of my know basis of examinat oner stated.	wledge, death tion and/or inv	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and ma ate and place,	inner as st and due to	ated. the cause(s)		
	To th To th	Me	29b. Signature and	title of certifier	011			29c. License		2	9d. Date signed	d (Month, I	Day, Year)		
	/		1	1C/~	Y(N)	35		105	3850		OCT -	5, 2	2005		
•	5		30. Name and addre	ess of person w	who completed cau	se of death (ftem	23а) (Туре,	Print)			301.	-, -			
					WARTZ, M			ROCKVILL	E PIKE,	ROCKVILL	E, MD.	20852			
8	- Sta	ate	31. Date filed (Mont	th, Day, Year)	32	Registrar's Signar	turn 4	de							
7	Regist	rar	O.	CT OR	2005	aux D	450	-60							

OCT 06 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 State
Registrar Amend #26. Per Phys. PGC 10-4-05 cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Month Mattie D. Williams September 26 03:04 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 416-46-9756 70 Yrs. 19, 1935 Alabama Director May Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f show traumatic event, the Maulcal Examinational Le notitied at 1XYes 2□No Maryland Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3408 - 55th Ave. 20784 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: Black by 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Nursing Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charlie Miles Louise Barber 2 permit. Pages 1 and 2 should be constituted to the postument of Health and Millimportant: If item 27 is martary injury or other traumations. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4919 A St., S.E. #302, Wash., DC 20019 Kevin B. Williams/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10/3/2005 Ft. Lincoln Cemetery 4 □Donation 5 □ Other (Specify) Brentwood, MD 21. Signature of Fun and Service Licensee 22. Name and Address of Facility Stewart Funeral Home - Herry 4001 Benning Rd., N.E. Wash., DC 20019 non 23a. Part 1. Etc. the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death myocardia Physician /Medical Due to (or as a consequence of): Examiner wone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 1 Yes 2 No 1 Yes 2/2/No Hospital or Attending Physician: Director: After this certific I in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ming Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide within 24 hours a 💹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055120 Jept 27 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Suntan arene SE Such 310 Washing Lan De 20032 above mi Kicharo 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar OCT 0 4 2005

		•	For State Registrar	State	of Mary		artment of F rtificate of		Mental Hy	giere 0 0 5 Reg. No.	34070	
	Physicia /Medic		1. Decedent's Name (First, Midd MARGARE	1 0	WE	ElKos			2. Date of De. Month	Day Yes	3. Time of Death 7:00 AM	
	Examin		4a. Facility Name of not institution 212 St. Mark		ımber)		4b. City, Town, o Westmir		ath	4c. County of D	eath	
	Funeral Director		5. Social Security Number 219–18–0144	6. Sex 1 ☐ M 2 /2 F	7. Age (In 81	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		th Year) 1923 B	Birthplace (State or Foreign Country) altimore, MD	
	show		Usual Residence of Decedent 10a. State 10b. Count			c. City, Town or Lo Westminst					10d. Inside City Limits	
	r 28e-f	Funeral Director	MD Carro) <u>T.T</u>			10f. Zip Code			1 Yes 2 No		
	s 23a o	erai D	212 St. Mark W	_	1.5		21158	10 11	U.S.A.			
	72 hours efter deeth with the M natural', or Items 23a or 28e-f dical Examinar must be yediffle	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☒Widowed 4 ☐ Divorce	If Yes G	orces? 2 TN o iive	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 2 No	Ispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	Black, W	merican Indian, Thite, etc. White	
2	in 72 ho	Completed	(Specify only high	nt's Education est grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	rorking	16b. Kind of Busine	ss/Industry	
717	2 should be filed within 72 hours efter deeth with the Maryland and Mental Hygiene. Is marked other than. Is marked other than "natural," or Items 23s or 28e-f show eumatic event, the Madical Examinational Leindillied at		Elementary/Secondary (0-12)	4	(1-4or 5+)	Teach					City Schools	
	should be fi nd Mental H marked ott umatic ever	To Be	17. Father's Name (First, Middle Cecil Carter	, Last)				Alice		Maiden Sumame)		
ואומו א	permit. Pages 1 and 2 should be filed within 72 hours elter deeth with the Maryla Department of Health and Martal Hygiens. Important; if item 27 is marked other than "natural", or items 23s or 28e-f shot any injury or other treumatic event, the Maulical Examinar night by source.		19a. Informant's Name/Relation Steven E. Welk			19b. Mailir 2302	ng Address (Street Sandy Wa	and Number or I	Rural Route Numbe	er, City or Town, State MD 21113	a, Zip Coda)	
ווסומ,			20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Ob. Place of Dispo	sition (Name of matory or other place	ce) 10	Date	20c. Location - City Hampstead	or Town, State	
משוו	permit. I Depertm Importa any Inju		21. Signature of Funeral Service		1					meral Home	& Chapel, P.A	
			23a. Part . Enter the disease, of shock, or heart ailure. Lis	or complications that it only one cause on	caused the each line.						Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to	(or as a co	mysca	rdial	infor.	otion		minutes	
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ה ה ה	icate be executed physician and s the burial-transit	edical E		d	(0) as a co	risequence on).					0	
O. DOY O	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buffal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		birth 2 🗀	Fetal death 3	3 Ectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day					
, L	ss that the	by Phy	Part II. Other significant condit	ions contributing to	death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
	v raquire baen sig should b		Hyperly	denie	0 4	200. 4	-1. a	0			Probably 4 Unknown	
ב ב	The lav ate has page 2	Completed	Osteoart	britis	~ /\	yeux	auseas		24a. Was autop perfo		autopsy findings available to completion of cause of ?	
V 110	sicien: certificarector,	Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient	2 DEB/Outpotion	o Don Oth	or.	eath (Check only o	one)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2.	ation: To	27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date		2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor			dence 6 Other (S, now injury occurred	pecify)	
בואום	al or Atter after des Director d in by the	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 289. Place	e of Injury - ding, etc. (S	At home, farm, stripecify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,	
	ne Hospita 24 hours ne Funere	edical C	29a. Certifier (Check only one) Certify 2 Madica	I Examiner: On the	e best of mo basis of exa nner stated.	y knowledge, death mination and/or inv	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)	
		Me	29b. Signature and title of certific		7. 0.1	DO	29c. Licens	e number	2/.	29d. Date signed (Mo	onth, Day, Year)	
	W20		30. Name and address of person		ise of death	(Item 23a) (Type.	Print)	o la c	A M N	21158	/ 03	
	Sta		31. Date filed (Month, Day, Yea	r) 32.	Registrars	Signature	y war	Tar part)	27700		
	Registr	वा	UUT	1 3 2005	The state of	w K.	Brack .					

			For State Registrar	State of Maryland		irtment of H tificate of L		Reg	2005	34071
	Physicia	an	1. Decedent's Name (First, Middle, Last) Frederick A. Burdet	-t-o				2. Date of Death Month	15, 2005	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give s			4b. City, Town, or		octobel	4c. County of Deat	
	LXammi		St. Joseph Medical	Center		To	wson	Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 216-12-7579 Usual Residence of Decedent	7. Age (In yrs. la	ast birthday). Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y October	(ear) 9. Birt. Co 11,22 Mar	nplace (State or Foreign untry) y Land
	show	ja	10a. State 10b. County Maryland Baltimore		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Marylar sa or 28e-f show the rediffed at	Funeral Director	10e. Street and Number 13720 Princess Anne			10f. Zip Code	131	7	citizen of What Co	•
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Important: if files 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumetic event, the Medical Exam actinistics redifficat at once.	by		2. Was Decedent Ever in U.S Armed Forces? 1 Āves 2 □ No If Yes, Give Year or Dates: ₩.₩.		Vas Decedent of Hi Yes, specify Cubai	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: VI	
2.0.7	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	completed) College (1-4or 5+)	(Give :	OO NOT use retired,	luring most of worki)	ng	ib. Kind of Business/	
7	led wii lygien her th nt, the			04		Corpora	te Buyer	ST. (First, Middle, Ma		Blue Shield
ם ב	uld be fii Aental H rked otl tic ever	To Be	17. Father's Name (First, Middle, Last) John C. Burdette		ouise Bi					
Z Z	2 shoi and N is ma		19a. Informant's Name/Relationship (Type		1	•			City or Town, State, 2	
ב ט	1 and Health 6m 27 ther tu		Mrs. Alina R. Burdet			PYINCESS sition (Name of natory or other place	Anne Way		ix, Maryl.	
	t. Pages tment of l tant: If it		1 Z Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	More	eland i	Mem.Park	Oct.			e,Maryland
מ	Departing Departing Support Publisher Publishe		21. Signature of Funeral Service License	F. Jan.		15 YORK K	oad Titi	nonlum. M	arviand	on Ctr.,P.A. 21131
ı	Physician		23a. Part Ener the disease, or complication of heart failure. Ust only on Immediate Cause (Final disease or condition			er the mode of dying	g, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					
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cords, r	quires that n signed b uld be deta	by	Part II. Other significant conditions con	A	Iting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to 2 ☐ No 3 ☐ Pr	the cause of death?
מפנס	The law red te has bee bage 2 shot	Completed	•					24a. Was an autopsy performe	prior to	itopsy findings available completion of cause of 2 No
119	clan: ertifica ictor, p	Be C	25. Was case referred to medical examiner?					(Check only one)		
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5 50	tding th. : After s funet	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work		Edd. Boddillo flow	injury occurred	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	e Hospita 24 hours e Funerel letely fille	Medical C		ician: To the best of my knowner: On the basis of examinat and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	Mam		29c. License	32453	_	I. Date signed (Mont	h, Day, Year)
	15×1		30. Name and address of person who co	npleted cause of death (Item 4005	23а) (Тура. СП	Print			1 Hunt	Valley, MD.
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 2	32. Registrar's Signat	ture	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 2:05 PM 2005 aulon /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 7. Age (In yrs last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1**X**XM 2□ F Hours Yrs. 217-55-0742 Director 6 07/01/1999 Ilford England Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "neturel", or Items 23a or 28e-1 show of care Examiner a ust be notified at 1 Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citîzen of What Country? 3570 Courthouse Drive #3B 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X Yoo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "neturel", or Itel 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary Education Student Kindergarten 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cindy Olajide Fred Bisong ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Olajide (mother) item 27 3570 Courthouse Drive #3B Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages i Department of F Important: If ite eny injury or ot XXBurial 2 Cremation 3 Removal from State 10/22/2005 Crestlawn Memorial Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deatt Immediate Cause (Final **Physician** 22 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 2 No 1 X Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 and title of certifier 29c. License number 29b. Signat ATTENDING 00057412 2005 PHYSICIAN ddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 600 N.

32. Registrar's Signatu

BROWN

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of	Marylar		artmen rtificate			and M	ental Hyg	giene Reg. No.2	005	341	073
	Physic	an	1. Decedent's Name (First, Middle, Las	1)							2. Date of Dea Month	Day	Year	3. Time o	of Death
	/Medi		Patricia Ann Boo				1				Oct 19	, 200	5	8:33A	M
	Exami	ner	4a. Facility Name (If not institution, give Catonsville Con		ιer)				Location o	of Death			ounty of De		
-	Funeral		5. Social Security Number 6. Se	nmons	Age (In vrs.	last birthday)	If Under		ille	24 Hrs.	8. Date of Birtl		ltimo		or Corpian
	Director			744 WT E	3	Yrs.	Months	Days	Hours	Min.	(Month, Day	7. Year) 1942		inthplace (State Country) t VA.	or roreign
	p		Usual Residence of Decedent		10.0							1312	IIIC		
	laryla ehov	2	10a. State 10b. County			ity, Town or Lo								10d. Inside C	
	th the Marylandor 28a-febow	ecto	Md Baltimor	<u>e</u>	H	aletho	_	Cada				10 0::	(144)		2 No X No
	with ga or	ă	1950 Victory Drive	<u>م</u>			10f. Zip	21227	7			-	n of What C	ountry?	
	within 72 hours after death with the Maryland ene then "natural", or iteme 23e or 28e-f show the Madical Exeminer must be natified at	Funeral Director	11. Marital Status	12. Was Decede		J.S. 13.				gin? (Spe	cify Yes or No- Rican, etc.)	US 14		erican Indian,	
9	after or its	Ē	X☐ Never Married 2☐ Married	Armed Force 1 ☐ Yes 2 If Yes, Give		1	lfYes,spec 1 □ Yes 🕽			, Puerto F	Rican, etc.)		Black, Wh		
003	urai',	d by	3 Widowed 4 Divorced	Year or Date	es:		Tes 2	LU NO	Specify:			S	ecity: Wh	ite	
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b	lbe filed with nat Hygiene od other the event, the	Be C	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle,	Maiden Su	mame)		
/lar	▼ 5 5 €	To B	Ernest C. Boggs						Myr]	l R.	Murphy				
Maryland 21215-0036	0.00		19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address	(Street a	nd Numbe	r or Rural	Route Number	r, City or T	own, State,	Zip Code)	
	and and lealth m 27 in		Linda K. Lewis- S	oister	122	-			or. Ha	120 - 000	norpe, I	Md 21	227		
Baltimore,	0 0 = =		20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ F		ate (Place of Dispo cemetery, cren	natory or ot	her place	' I		ate	20c. Local	ion - City o	r Town, State	
Ħ.	Department Department mportant: Iny injury c	ı	4 □ Donation 5 □ Other (Specify)		Me	adowri	dge Me	em. 1	Pk.10	/21/	2005	Elkri	.dge,	Md	
Ba	Dep Imp		21. Signature of Funeral Service Licens	teuter	~~									Hm at Me Blvd.	
d	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of mediate Cause (Final disease or condition resulting in death)	a	sed the death line.						respiratory arr		, 110	Interval Bet Onset and	ween
8760, <	rate be executed any system and the buriat-transit	ical Exa	Couperitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	as a consequate as a consequence	uence of):		Nel	lit	45				ブ	4.
P.O. Box 6	that the death certifical ed by the ettending phi detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	l3c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	2 ☐ Feta tat time of d	ıldeath 3⊡	Ectopic pre					23d	. Date of de Month	•	Year
of Vital Records, P	8 5 6	d by P	Part II. Other significant conditions co	ntributing to deat	n but not res	ulting in the ur	iderlying ca	use givei	n in Part I.			oacco use		o the cause of d	
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R	The lav	E									autops	ned?	prior to death?	completion of c	ause of
ital	ician: Th certificete rector, pag		25. Was case referred to medical				-		26. Place	of Death	1 ☐ Yes 2 Check only on	el No	1 L Yes	s 2□ No	
<u>></u>	Physician: this certific ral director,	卢	examiner? 1 ☐ Yes 2 No	fospital: 1 🗆 Inpa	atient 2 🗆	ER/Outpatien	3 DO	Other	4 Nur	sing Hom	e 5 ☐ Reside	ence 6	Other (Spe	ecify)	
ion	After fune	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of li (Month,	njury Da <i>y Year)</i>	28b. Time of Injury	28 M	ic. Injury Work?		28	3d. Describe ho				
Division	o agini c	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building,	Injury - At he etc. (Specif	ome, farm, stre	et, factory,	office		28	Bf. Location (St. City or Town	reet and N n, State)	umber or R	ural Route Num	ber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 11 Certifying Physics (Check only one) 2 ■ Medical Exami	sician: To the be ner: On the basis and manner	s or examina stated.	tion and/or inv	estigation, i	in my opi	nion, death	occurred	d at the time, da	ate and pla	ce, and due	to the cause(s	
	To t with To t	Σ	29b. Signature and title of certifier	o	17,	Henry	A 29c.	License	number 6 9 4	2	6	9d. Date si	gned (Mont	th, Day, Year)	°5
	3		30. Name and address of person who co	mpleted cause o	f death (Item	23a) (Type, i	Print)	140	Rd	. C	; tery s	'cle,	M	21228	3
3:	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signa	ture	ali)			,					

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			State of Maryland / I	Department of Health and M Certificate of Death	ental Hygier	
-	. T	F. A	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
2		sician edical	Evelyn Beluscheck		October 1	19, 2005 4:35 P M
1	2,000	miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
35		4 - 6	Stella Maris nursing Home	Timonium		Baltimore
* .	Fune	50	5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 M 2 🗓 F 94	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birthplace (State or Foreign Country)
7	Direc	tor	Usual Residence of Decedent		Nov. 20,	1910 Kentucky
R	death with the Maryland me 23a or 28e-1 show	i .	10a. State 10b. County 10c. City, Tow	vn or Location		10d. Inside City Limits
-0	e Ma	cto	Maryland Baltimore Timoni	Lum		1 ☐ Yes 2 No
5	ith th	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
0	ath w	rai	2300 Dulaney Valley Road	21093		S.A.
300	ter de Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \[\text{Never Married} \] 2 \[\text{Married} \] 1 \[\text{YE} \] No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
el	0036 hours after tural; or ite	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Yeo Specify:		Specify: White
0	5-0036 72 hours at natural; or	Completed	15. Decedent's Education 16a	a. Decedent's Usual Occupation	16b	. Kind of Business/Industry
-	within 7	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	ig -	
0/	nd 2121 e filed within al Hygiene. I other than	S		Iomemaker		Own Home
11:	be fill Hall Hall	Be	17. Father's Name (First, Middle, Last) Richard Swan		(First, Middle, Maid	en Sumame)
SE	Taryland 2 should be f and Mental B 16 marked of	2		Flossie		T 0 1 1
B	Maryland d 2 should be file th and Mental Hy ty le marked oth		1.2.1	b. Mailing Address <i>(Street and Number or Rura)</i> 3309 Central Western S		
10	on 1 and 1 a					Location - City or Town, State
0	Pages ent of		Laboral 2 Comment 3 Chemoval norm State	swood Cemetery 10-24	-05	akbrook, IL
3	Baltimore, permit. Pages 1 ar Department of Hea Important: If teem	Ŕ	21. Signatur of Funeral Service Licensee	22. Name and Address of Facility		
\circ		DUC	a sennis VIII main	Coglianese Funeral	e Rd., Bu	rr Ridge, IL 60527
HELYN	Box 68760, (A) Sauth certificate be executed attending physicien and for use as the burial-transit	a a la	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the condit	ON'S DISEAS		Interval Between Onset and Death
X	. 0 00	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknowrr 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ECI	ords, P.O requires that the een signed by the rould be detached.	Ď.	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 \(\sum No \) 3 \(\sum Probably \) 4 \(\frac{1}{2} \sum Onknown \)
+	() > 0	Completed			24a. Was an	24b. Were autopsy findings available
7	The I	, E			autopsy performed? 1 Yes 2	prior to completion of cause of death? 1 □ Yes 2 □ No
5	Vital Resident The law certificete has rector, page 2	Be	25. Was case referred to medical examiner?	26. Place of Death		10 103 20110
0)	of Vita Physician: this certific	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Other: 4 Nursing Hom	ne 5 🗌 Residence	6 Nother (Specify) Hospice
1	ing P	on:	1 Natural 5 Pending (Month, Day Year)	Injury Work?	8d. Describe how in	jury occurred
7	Division or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	0()	
M	Div A after after Direction by	ertif	4 Homicide determined 28e. Place of Injury - At home, fa	arm, street, ractory, office	City or Town, Sta	and Number or Rural Route Number, ate)
B	Division of Vital Re To the Hospitel or Attending Physician: The leating 4 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	death occurred at the time, date and place, and/or investigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stated and place, and due to the cause(s)
_	To th Within	Me	29b. Signature and tiple of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
			/	D43720	10	119105
	(3)	7	30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		7
	\		TARIQ MAHMOOD, M.D.	2300 DULANE	Y VALL	EY ROAD
	- A. W. M.	State istrar	31. Date filed (Month, Day, Year) 32. Registrat's Signature	(Type, Print) 2300 DULANE	Timon	ium, MD 21093

DHMH 17 Rev 1/2001

			For State Registrar	State of I	Maryland		artment of H tificate of L		nd Ment		ene . No. 🤈 (ne	01-0
	Physici /Medi	al	1. Decedent's Name (First, Middle BEL VA [Machine In the Company of the Company	JEA	AN.	e	Black	I acation of	O	ate of Death onth LTOBEL	Day 8 1 2/	Year 2005	3. Jimetof Death 5
18	Examir Funeral	ier	4a. Facility Name (If not institution, The Johus 5. Social Security Number	HOPKINS	Hosp	DI HAL ast birthday)	4b. City, Town, or BAI	time If Under 2	PRE C	1'+y		y of Death 9. Birthp	place (State or Foreign
	Director		464-34-2976 Usual Residence of Decedent 10a, State 10b, County	1 M 2	76	Yrs.	Months Days	Hours	Min. Feb	ate of Parth fonth, Day, Y 2, 19	929		York 10d. Inside City Limits
	r 28a-f sho	Director	Utah Davis 10e. Street and Number			arming				10g	. Citizen of		1 Yes 2 □ No
36	72 hours after death with the Maryland neturel', or Items 23s or 28s-f show dissal Examiner must be notified at	by Funeral D	1639 W. 1290 No. 11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Decede	ss? XNo		84025 Was Decedent of Hif Yes, specify Cubar	spanic Orig n, Mexican, Specify:	in? (Specify Y Puerto Rican			ce - Americack, White,	etc.
121215-0036	d within piene. r then "	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	college (1-4)	or 5+)	(Give life. l	dent's Usual Occupa kind of work done d DO NOT use retired, nemaker	uring most				Business/Ind Home	
Maryland	be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, I Rolen Duane Jes 19a. Informant's Name/Relationsh	S		10h Mailie	ng Address (Street a	Ne	ellie M	iller	Swan		Code
Baltimore, Ma	ss 1 and 2 s of Health ar item 27 is r other treu		William Black — 20a. Method of Disposition 1 Surial 2 Cremation 4 Donation 5 Other (Sp.	Husband 3 □Removal from Sta	ate ce	1639	W. 1290 sition (Name of natory or other place	North		ington	, Uta	h 84 - City or To	4025
	permit. Page Deportment Importent: If any njury o		21. Signature of Funeral Service L 23a. P. 11. Enter the disease, or nock, or neart failure. List of 1 nediate Cause (Final 1 sease or c. dition	mplications that cau	h line.	. Do not ent		s of Facility Other Main g, such as c	s Fune St. B ardiac or resp	ral Ho ountif iratory arrest	me ul. U		
	/Medical Examiner Ician and portial-Itansit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseque as a conseque as a conseque	ence of):	HIVE .	PlAC	EMEL	T			2 HRS
O. Box 68	death certifi e attending i d for use as	Physiclan/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		n 2 ☐ Fetal tat time of de	death 3	Ectopic pregnancy Other (specify)					ate of delive	ery Day Year
rds, P.	es De pe	þ	Part II, Other significant conditio	ns contributing to deat	h but not resu	Iting in the ur	nderlying cause give	n in Part I.	2	3e. Did tobac	cco use con		ne cause of death?
Vital Record	The law ate has b page 2 sl	Completed					<u>. </u>		_	4a. Was an autopsy performed	d?	prior to cor death?	psy findings available mpletion of cause of
ot	ding Physicien: Th th. After this certificate funeral director, pag	To Be	25. Was case referred to medical example? 1			ER/Outpatien 28b. Time of Injury	28c. Injury Work	^{r:} 4□ Nurs					1)
Division	spital or Attending ours after death. lerel Director; After filled in by the fune	ertification;	3 Suicide 6 Could n 4 Homicide determi	ot bo	Injury - At hor etc. (Specify)	me, farm, stre	eet, factory, office	_	28f. Lo	cation (Streety or Town, S	et and Numl State)	ber or Rura	I Route Number,
	HOS HOS Bly	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basi and manner	s or examinati	vledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and inion, death	place, and du occurred at t	e to the caus he time, date	se(s) and mage, and place,	anner as st and due to	ated. the cause(s)
•	To the within 2 To the complet	W	29b. Signature and title of contier	Vin 1	MD		RES		00		Date signe		
	Sta	te	30. Name an address of person of the person		of death (Item 1D istrar's Signati	23a) (Type, 600 aure	WORTH W	olfe s	St., BA	altim	ORE	, MD	2, 20 <i>05</i> 21287
	Regist	_	061212	UUS Bloom	istrar's Signati	4000							

Riessine WAME: HELEH or 28a-f show

"netural", or items 23e

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than

injury or other traumatic event, the Medical Examinar must be notified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. 16. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1055RM 18 CETOBER Helen Eugenia Blessing /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KWER E If Under 1 Year If Under 24 H/s. 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 10/15/1909 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 🂢 F Yrs. Director 96 212-52-7620 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8619 Silver Knoll Drive 21128 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Harry Ridgeway Conklin Dorothy Elizabeth Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey R. Blessing (son) 8619 Silver Knoll Drive - Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 10/22/2005 Baltimore, Maryland 22. Name and Address of Facility E.F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses 60 11750 Belair Road - Kingsville, Maryland assa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nyocardel disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last en sio Examiner Due to (or as a do Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 live birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _ 2 No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 1 Natural 5 Pending 1 🗌 Yes 2 \(\sum No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

Examiner the attending physician and thed for use as the burial-transit that the death certificate be executed Box 68760, P.O. signed by Division of Vital Records, pe certificate has After this

e Hospitel or Attending Pl 24 hours after death. e Funerel Director: After th

within 24 hours a To the Funerel C State

Medical

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

4 - Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 Mas Charl

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 apor fb 2850 12-8-95 With and Mental Hygiene 1 - For State Registrar Reg. NG 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** PEACH BURTON OCTUBER 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. 2165-60-19892 6. Sav Examiner ASADENA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Months Days Hours Min Director -10 Usual Residence the Maryland 10c. City, Town or Location 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or items 23a or 28e-f show ury or other traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits MD 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RINE AVE e filed within 72 hours after death all Hygiene.
I other than "natural", or items 234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced HITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be MARY TRANK WELLINGTON BACKMANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA CAROLKA permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once. STMINISTER, MD. 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BAYVIEW CREMATORY 5 Other (Specify) ⁴ 4 □ Donation 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death 23d. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Smoth disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 ☐ Yes Division of Vital the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident ospital c.
4 hours after deau...
ral Director: Afr 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) October, 18 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Hospita 5 SAWHNEY GlenBa GULMEET 31. Date filed (Month, Day, 2 1 2005 egistrar's Signature Registra

			Amend item 19b per fft 848 1	0-21-05 vt partment of Health and	Mental Hygie	ene	
			1 - State C	ertificate of Death	Reg	I Nag O O C O L O T	0
В	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	b
	/Media	cal	Hattie Bell 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	October	13 2005 11:31 4c. County of Death	þ
	Examir	ier	3575 Riva Road	Davidsonville		Anne Arundel	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		s. 8. Date of Birth		gn
	Director		218-16-3169 1 M 2 T F 81 Yrs.	Months Days Hours Mil	Nov. 10	1924 Maryland	
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limit	ts
	Marylan I-f ehow	to	Maryland Anne Arundel Harwoo	3		X2Yes 2□N	lo
	or 28g	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Country?	
	ath w	rai	4406 Sands Road	20776		USA	
	ltem Item	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 	(Specify Yes or No- erto Rican, etc.)	 Race - American Indian, Black, White, etc. 	
920	urs aff	<u>م</u>	1 ☐ Never Married 2 ☐ XMarried 1 ☐ Yes 2 X ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: Black	
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow disal Examinat must be notified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	nding 16	6b. Kind of Business/Industry	
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	filed with Hygiene. Ather thai		12th 0	Bus Aid	ame (First, Middle, Ma	o. Public School	S
Maryland	4 d a 8	To Be	John T. Owens Sr.		ietta Tu	· ·	
ary	and Menide marketermar	۲	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or I	Rural Route Number, C	City or Town, State, Zip Code)	
	and 2 lealth a m 27 le			Fiva Sands Rd.	Harwood,	Md. 20776	
Baltimore,	ges 1 ar it of Hea if item or other		1 Burial 2 □ Cremation 3 □ Bernoval from State cemetery, c	position (Name of rematory or other place)		c. Location - City or Town, State	
Ë	t. Paritmen rtant:		4 George George		21/05 Ha	rwood, Md.	
Ba	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee Larry H. Rease Mos 483	22. Name and Address of Facility Wm. Reese & Sc 821 West St. A	ns MOrtu nnapolis	ary, P.A. , Md. 21401	
			23a. Pan1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardi	ac or respiratory arrest	t, Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	y failure		Onset and Death	
	/Medical Examiner						7
		er	Sequentiany list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	en organ of	ailure	2 month	6-9
*	cuted nd ransit	Examiner	that initiated events	Lateral S.	cherosis	January 20	203
90,	The law requires that the death certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit		resulting in death) Last Due t1 (or as a consequence of):				
8760,	physic physic the b	Physician/Medical	d.				
Box 6	eath certific	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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P.0	at the de by the	hys	9 ☐ Unknown 9☐ Unknown				
	res tha igned be det	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?	
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Records,	has l	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?	ө
Vital	an: The l tificete ha tor, page	င္ပ	25. Was case referred to medical		1 Yes 2		
Š	ysicia is cert directe	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Othor	Home 5 Residence	ce 6 vother (Special) Besiden	
n of	Attending Physician: r death. ector: After this certific by the funeral director.	- 1	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		در
Sio	death. ctor: Af	catic	2 Accident investigation	M 1 Yes 2 No			
Division	for At after d Direct	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
_	Hospita 4 hours Funeral 1ety fillec	edical Co	29a. Certifier (Check only conditions) 29a. Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and plac investigation, in my opinion, death occ	ce, and due to the caus	se(s) and manner as stated.	- 17
	To the within 2 To the complet	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)	
	- > - ō	Ä	Della h D.S.	400474		10/14/05	
	h		30. Name and address of person who completed cause of death (Item 23a) (Typ	a, Print)			_
					Fr. An.	nopolio, mg zivi	-3
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 2005	Sale J			
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State of Maryland / Department of Health and Mental Hygien 2005 34079 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Year Edith Elizabeth Barnes 3:30P.M Oct 19 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing Home Walkersville Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2**K** F Months Days Yrs. Director 219-20-3412 Maryland May 8, 1925 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Directo Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 9310 Stauffer Road 21793-7603 itams 23a United States Funera filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 8th Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental P ပ James Ezra Pickett Renee Virginia Porter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other treu daughter 9310 Stauffer Road Walkersville, MD Nola Ramsburg 21793-7603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) oct. 23, 2005 Lingangre Cemetery Unionville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA Celle 21784 1212 W. Old Liberty Road Sykesville, MD ter the mode of dying, such as cardiac or respiratory arrest. 23a art1 Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset an eath Inmediate Cause (Final tiseas) or condition ting in death) **Physician** /Medical Due to (or was consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed) 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how intury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2005 tho completed cause of death (Item 23a) (Type, Print) FRED MD 1475 OCT 2 State 2005 Registrar

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	Physici		1. Decedent's Name (First, Middle, Last) MARY BRUMLEV	E		M	ate of Death onth Da	ay Year 2005	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number)			Location of Death	7	c. County of Death	'
1,69	A. A.	ar ing	HOWARD COUNTY GENERA			MMBIA		towar	
5	Funeral Director		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday) Yrs.	Months Days		ate of Birth lonth, Day, Year		place (State or Foreign ntry)
1 X.	TO TO		Usual Residence of Decedent			וווער	y 10 , 192		imis
	arylar show	2		Oc. City, Town or Lo					10d. Inside City Limits
	the M	Director	Maryland Carroll 10e. Street and Number	Mt. A	10f. Zip Code		10= 0	itizen of What Cou	1 ☐ Yes 2√ No
	3a or	10	812 Parade Lane		101. 21p Code	21771		United Stat	-
	death	Funeral	11 Marital Status 12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hi	spanic Origin? (Specify Y n, Mexican, Puerto Rican,		14. Race - America	can Indian,
39	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene, item 27 is marked other than "neturel", or iteme 23a or 28a-f show other traumetic event, the Madical Examinat must be notified at	by Fui	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes Give Year or Oates:		1 ☐ Yes 2X No	n, мехісап, Риепо Нісап, Specify:	etc.)	Black, White, Specify: Whi	
21215-0036	72 hou		15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation furing most of working	16b. F	Kind of Business/In	
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	Hygier Hygier Ther th		2 years		Housewif	18. Mother's Name (First	Adiadala Adaida	own han	re
ano	d be i	To Be	Lawrence Kerwin			Merle Cocd		ir Sumame)	
Maryland	2 should be filled within and Mental Hygiene. Is marked other than aumetic event, the His	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rural Rout		or Town, State, Zij	o Code)
	1 and 2 Health a em 27 is		Robert Brumleve husband	812	Parade Lane	Mt. Airy, MD	21771		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 sny injury or other tr once.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State		matory or other plac		111 11125	ocation - City or To	
틢	permit. Pages Department of Important: If it any injury or c		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Pine Grove	2. Name and Addres	oct. 23, 2	2005 Mit	t. Airy, Ma	ryland
Ba	permit. Departr Importu any inju		Valley 16 Call	, E	Arrier-Or	n Funeral Home	& Cremato	DCY PA MD 21784	
	* = :		23y. Part Enter the dise se, or complications that sused the shoot, or heart failure. List only one cause or such line.	ie death. Do not ent	ter the mode of dying	Liberty Read g, such as cardiac or resp	iratory arrest,	, ND 21784	Approximate Interval Between Onset and Death
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O. E	the the	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Month	Day Year
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_	yeician: The is certificate hi director, page	Con	injected decubitus	ulcer		10	performed? ☐ Yes 25 No	death?	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Othe	26. Place of Death (Che			
o	Phys r this ral dis	2	1 ☐ Yes 2 ☑ No Hospital: ji ☐ Inpatient 27. Manner of Death 28a. Date of Injury.	2 ER/Outpatier	f 28c. Injury	4 Nursing Home 5	Residence		(v)
lon	nding Ph ith. :: After th e funeral	tlor	1 Natural 5 □ Pending (Month, Day Y 2 □ Accident investigation	ear) Injury	Work	? /es 2 □No		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director,	Certification:	a Could not be	- At home, farm, str (Specify)	reet, factory, office		cation (Street ar ty or Town, State	nd Number or Rura	al Route Number,
	pital ours a eral D		29a. Certifier (Certifying Physician: To the best of	my knowledge, death	b accuracy at the time				
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of examiner: On the basis of examiner and manner state	camination and/or in	vestigation, in my op	inion, death occurred at the	he time, date an	d place, and due to	o the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier		29c. License		29d. Da	ate signed (Month,	Day, Year)
	/		► Mus, MD, FCCP		936	5845	00	t. 19,	2005
	b		30. Name and andress of person who completed cause of dea	0	0	CHI NEU	YEN,	MU, FO	CCP
100	Sta	te	31. Date filed (Month, Day, Year) 32. Registrars	Signature.	usa,	MIDAI	044		
	Registr		UCI 2 1 2005 Meet	w It A	mede				

1410-531-0700

		•	For State Registrar	State of M		Departme Certifica	nt of H	lealth a		•			34081
			Decedent's Name (First, Middle	, Last)						2. Date of D			3. Time of Death
	Physicia		Marion	С.		В	rush			Octob	er 1	8,2 ^{Year} 8	4:55A M
	/Medic Examin		4a. Fecility Name (If not institution,	give street and number)				r Location o	of Death			county of Death	1.0011
		Ŭ.	Eastpoint Reh	ab & Nurs	ing Cer	nter D	ındall	k			I	Baltimor	re
	Funeral Director		5. Social Security Number 219–18–4600		je (In yrs. last bi		er 1 Year s Days	If Under:	24 Hrs. Min.	8. Date of B (Month, D May 1.	irth Pay, Year) 3,1925	9. Birthp Cour	lace (State or Foreign try)
	pu ,		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tov	m or l costico							04 (- 14 0) 11 1
	anyla shov	٦		_								'	0d. Inside City Limits 1¾□ Yes 2 □ No
	Ba-f	ecto	MD N/	A	Balt	imore							
	with t	급	10e. Street and Number 6434 Hartwait S	troot		101. 2	ip Code	224			_	en of What Cour	itry?
	s 23	rai			5	1.0.111			1 8 10				
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if Itam 27 is marked other than "natural; or Itams 23a or 28a-f show Injury or other traumetic event, The Medical Exertification to nutified at 8g.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	,			ispanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)		4. Race - Americ Black, White, Pecify: Whi	etc.
9	2 ho	Completed	15. Decedent	s Education	16a	. Decedent's Us	ual Occup	ation	A = 6		16b. Kind	d of Business/Inc	dustry
3	within 7 ene. than "r	pie	(Specify only highes. Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of v life. DO NOT	use retired	during mosi d)	t of works	ng			
7	gien dien	NO.	12 years	J		Sodderi	ng				West	inghous	e
b	be filed Ital Hygi d othar	Be (17. Father's Name (First, Middle, L							(First, Middl	e, Maiden S	umame)	
<u>a</u>	Aents Aents rked tic e	10 E	Thomas J. Pette	У				Mai	ry A.	lthoff			
ar	sho s ma		19a. Informant's Name/Relationsh	nip (Type, Print)	191	. Mailing Addre	ss (Street a	and Numbe	er or Rura	l Route Num	ber, City or	Town, State, Zip	Code)
	and 2 alth a 27 i		John P. Brush	Husb	and 6	5434 Har	twait	t Stre	eet,	Baltir	more,	MD. 212	22
Baltimore,	Pages 1 and part of He ant: if Itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		cemete	of Disposition (A bry, crematory of Heart Of	other plac		cto 22,2		_	ation - City or To	wn, State
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fundral Service L	2 VI		22. Name Conne 7110	and Address LIY I Solle	ss of Facility Funera ers Po	al Ho	ome of Road,	Dunda Dunda	lk,P.A. lk,MD.	21222
П			23a. Par 1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death. Do	not enter the m	ode of dyin	g, such as	cardiac c	or respiratory	arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	CERE									Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a conseguence	of):	4/07	V201000	- 0,5				
	Examiner			COROL	LARY	ARTE	CZX	101	SE	ASE			
		Je.	if any, leading to immediate	Due to (or as	a consequence	of):	1	1	0.	-	÷		
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	GING	5571V	EH	EAR	251	KAI	LORZ	_		
ó	execan an an arrial-ti		resulting in death) Last	Due to (or as									
760,	ate be executed lysician and he burial-transit	cal		CHROI	a consequence	11357	MO	10%	· /	PNG	DISE	135	
9	iffical g ph) as th	edi											
.O. Box	The law requires that the death cardifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1	2 Fetal death	3 □Ectopic 5 □ Other ('			23	d. Date of delive Month	ry Day Year
P.0	at the	Phy	9 Unknown										
	w requires th been signec should be d	by	Part II, Other significent condition	ns contributing to death b	out not resulting	in the underlying	cause give	en in Part I.			Yes 2		ably 4 Dhknown
Vital Records,		Completed									s an opsy ormed? 2 No	prior to cor death?	osy findings available npletion of cause of
ita	Physicien: this certificatal director.	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only	оле)		
of V	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatient 3 1	OOA Othe	er: Nu	rsing Hor	me 5 Res	idence 6	Other (Specify)
0			27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury Work	y at k?	1	28d. Describe	how infury	occurred	
.0	Attanding r death. actor: Afte	atic	2 Accident investig	ation		М	1 🗆 '	Yes 2□!	No				
Division	i or Attano after deatt Diractor: I in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of in	jury - At home, fa c. <i>(Specify)</i>	arm, street, facto	ory, office			28f. Location City or To	(Street and awn, State)	Number or Rura	l Route Number,
	urs a urs a ural C	ပိ											
	To the Hospital or At within 24 hours after o To tha Funaral Dirac completely filled in by	edical	29a. Certifier Certifying (Check only one)	g Physician: To the best Exeminer: On the basis of and manner st	of my knowledg of examination ar ated.	e, death occurre nd/or investigation	od at the timon, in my of	ne, date an pinion, deal	d place, a th occurr	and due to the ed at the time	cause(s) a , date and p	nd manner as st lace, and due to	ated. the cause(s)
ì	To t To t	Σ	29b. Signature and title of certifier	0x 1, 6,	,01, n	17)	9c. License	e number	75		29d. Date	signed (Month,	Dey, Year)
	d		30 Name and address of person v	who completed cause of	death (Item 23a)	(Type, Print)	0.	_/10	U		10	1-10	
	0		(pin man	12/1/11/16	21	rela-	140	d	1)()	usa	CON	10 2	1222
	Sta	te	31. Date filed (Month, Day, Year)		rar's Signature		.0	-	7 2	1400	,	,	
	Registr	-	OCT 2	1 2005	eve &	Span							

NO			1- For Unpend Item 2 Registrar	State of N 3a,27,28a	Maryland / Del	cartment of l G848 10-2 ertificate of	dealth and 05 tas Death	Mental Hy	giene 005	34082
	Physic	ian	1. Decedent's Name (First, Middle, La					2. Date of De	ath Day Year	3. Time of Death
	/Medi	cal	Tom Sawyer						er 17, 2005	6:20 p.м
	Exami	ner	4a. Facility Name (If not institution, giv Bourque Road & Hi	11 Pine R	oad	Essex	r Location of Dea		Baltimore	
2176	Funeral Director		5. Social Security Number 212-94-6760	ex 7. A	40 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bird (Month, Da April		thplace (State or Foreign Suntry) Aryland
	land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Many Many	tor	MD Balt:	imore		Essex				1 ☐ Yes 2X No
	n with the	i Direc	10e. Street and Number 1112 Hengemih	Le Ave.		10f. Zip Code 21	221		10g. Citizen of What Co	ountry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 23 a or 28a-f show important: if Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be motified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	?]No	B. Was Decedent of H If Yes, specify Cuba 1 Yes 2 Xno	ispanic Origin? (\$ an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		e, etc.
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	fucation	16a. Dec	edent's Usual Occup	ation	duna	16b. Kind of Business	Industry
2121	d within giene. er then "I	Completed	Elementary/Secondary (0-12) 12th	College (1-4or		re kind of work done of DO NOT use retired Cklift Di		rking	Pallet Co) .
land	itd be file fental Hy rkad oth	To Be C	17. Father's Name (First, Middle, Last) Edward Conner					me (First, Middle, Sawyer	Maiden Sumame)	
Maryland	od 2 shou Ith and N 27 is mai		19a. Informant's Name/Relationship (Kerrie K. Conr		19b. Ma	ling Address (Street)	and Number or Ri	ural Route Numbe	r, City or Town, State, 2 timore MD	Zip Code)
Baltimore,	ages 1 ar int of Hea t: if Itam y or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		20b. Place of Disp cemetery, cr		e)	Date	20c. Location - City or	Town, State
Baltir	permit. P Departme Importan eny injur:		4 □Donation 5 □Other (Specification 21. Signature of Funeral Service Licer			22. Name and Addres		11.000	Baltimore FuneralHo	meofEssex
	40200		23a Part 1 Enter the disease or com	10mil	lly	300Mac	eAve.	Baltimo	re MD 212	21
18.	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Cocaine	Intoxications a consequence of):		g, such as cardia	c or respiratory an	est,	Approximate Interval Between Onset and Death
	ecuted and -transit	Examiner	Sequentially list conditions, say, wat a condition of the course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	s a consequence of):					
68760,	icate be executed physicien and s the burial-transit	dical E		d.	s a consequence of);					
P.O. Box 6	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
	quires that en signed b uld be deta	þ	Part II. Other significant conditions of	ontributing to death I	but not resulting in the	underlying cause give	en in Part I.		bacco use contribute to	
I Records,		Completed						24a. Was a autops perform	V prior to c	topsy findings available ompletion of cause of
Vital	ician: certific rector,	Be	25. Was case referred to medical examiner?					th Check only on		
of	Phys this al di	2	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpati			4 🗆 Nursing 🗆		ence 6 NOther (Spec	
Division	ath. r: After	cation	1 ☐ Natural 5 ☐ Pending investigation		Found	P M 28c. Injury Work	at ? ′es 2 X ∏No		ow injury occurred	unk
Divi	rs after d al Direct ed in by	Certification:	3 ☐ Suicide 6 ♣ Could not be determined	building, e	jury · At home, farm, s tc. <i>(Specify)</i> n abandone			28f. Location (St City or Town Pine Rd.	reet and Number or Ruin, State) Bourque , Essex, MI	Rd.&Hill
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Ph	vsician: To the best iner: On the basis of and manner st	or examination and/or if	th occurred at the time	e date and place	and due to the or	ause(s) and manner as ate and place, and due	-4-4-4
)	To the To the comp	Ž	29b. Signature and title of certifier	Hallo	REALAND	29c. License OCM	number E	2	9d. Date signed (Month October 1	.8, 2005
			30. Name and address of person who c	ompleted cause of a	death (Item 23a) (Type	Print) 111 Pe	nn Stree	t Balti	more, Maryl	and 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	9				
	Registra	ar	OCT 2 1	PANS I	· · · · · · ·	line the				

DHMH 17 Rev 1/2001

ORIGINAL

				State of Maryland / Department of Health and Me	ental Hygier	2005	34083
	- Pro-10	.4	4.0	Trogram	2. Date of Death	*	3. Time of Death
		Physici	_	DOSEPH ALFORD CRTVELLO, NO		Day Year	600 AM
4	V3 -	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
•		LAGIIIII	101	UPPER CHESASTAKE RELAIR		HARFOR	0
	b. T	Funeral			8. Date of Birth Month, Day, Ye	0.00:41	nplace (State or Foreign intry)
		Director		217.26.9055 18M 20F 74 Yrs. Months Days Hours Min.	8-25-	31 MA	RYLAND
		DQ &		Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, County 10c. City, Town or Location			10d. Inside City Limits
		aho	ō	MD HARFORD RFL AIR			1 ☐ Yes 2 ☑ No
		the Marylar 28a-f ahow	ect	10e. Street and Number 10f. Zip Code	10a.	Citizen of What Cor	
		with a or	ā	113 SENELFIGHT RD. 21014	1	KA	•
		ne 23a must t	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	rfy Yes or No-	14. Race - Amer	
	ယ	after dea or itame minar m		1 Never Married 2 Married 1 Yes 2 No	lican, etc.)	Btack, White	, etc.
	5-0036	72 hours after death with the Maryland natural', or itame 23a or 28a-f ahow disal Examinat must be inclifted at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: ☐ .52 ☐ 1☐ Yes 2☐ No Specify:		Specify: V	HILE
	5-0	72 hours after death with the Maryla matural, or itame 23a or 28a-f ahoi idical Examinat must be mutified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin	g 16b	. Kind of Business/l	ndustry
	2121	.⊆ _ ⊇	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	C	IVIL D	ESIGH
	7	Hygie Hygie other 1		17. Father's Name (First, Middle, Last) 18. Mother's Name			
0	Maryland	e d is p	o Be	TOKERH A. CRIVELLO, SR ELIZA	RETH	GRA	J
3	2	should nd Men marke umatic	5	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number, Cit	ty or Town, State, Z	ip Code)
		and 2 ealth a n 27 is		ROSE CRIVELLO; WIFE 113 STONELEIGI	TT 20	BELA	12210KY
U	Je,	ges 1 a it of Hear if item or othe	- 4	20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition Disposi		. Location - City or	
5.	Ĕ	Pages nent of I int: If its iry or o			25	ELAR	,MD
Joseph Crivello	Baltimore,	permit. Page Depertment Important: If any Injury o		21. Signature a Funeral Server Licensee 22. Name and Address of Facility	WS FUL		
0	<u> </u>	89 = 9		Morezo 3 NEWPORT DE	TOPES	of the	WD STOR
,	1			23a. Piff1. Enter the disease, how is ations that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on ear hand.	respiratory arrest,		Approximate Interval Between Onset and Death
4		Physician		Immediate Cause (Final disease or condition	$\overline{}$		3 days
		/Medical Examiner		Due to (o) as a consequence p():	Alma	,	(Pera)
	8	LAGITITIO	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	01 0011)	e willie?
	V	ted nsit	Examine	Cause (Disease or injury			5 m = the
		be executed sician and burial-transit	xar	that initiated events c. Due to (or as a consequence of):			Q 13.0 L 1
10	760	ate be e nysiciar he buri		d			
05	68	ifficate g phys as the	edi				
1	XO	leath certifica attending pt I for use as t	M/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	
15	8	The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	Physician/Medical	in the past 12 months? 1 Yes 2 No		Month	Day Year
0	P.0	that the de ed by the a detached	Phy	3 C Unknown	Did tabas		the cause of death?
-		res tha iigned I be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	239. Did lobace		bably 4 Unknown
	orc	w require been si	eted				
	Vital Records,	e law has b	Completed		24a. Was an autopsy performed	24b. Were au prior to death?	topsy findings available ompletion of cause of
	alF				1□ Yes 2⊡	No 1 ☐ Yes	2 No
#			Be	25. Was case referred to medical examiner? 1		0.500	4.)
7	of	Phys r this ral di	: To	27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	8d. Describe how in	6 ☐Other (Special of the first	ny)
4	On	th. : Atter s tuner	tior	↑ Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
072214	Division	or Attending after death. Director; After in by the tune	Hice	s To C T Could not be	8f. Location (Street City or Town, St	t and Number or Ru	ral Route Number,
7	Ö	s afte s afte el Dir	Certification:	building, etc. (Specify)	Oily of Youri, S	(410)	
<u>_</u>		hour hour uner	dical	29a. Certifying Physician: To the hest of my knowledge death occurred at the time date and sold as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
		To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medi	one) and manner stated.		Date signed (Monti	
4		T of		29b. Signature and title of certifier 8 (29c. License number 29c. License 29c	IL A	cholon	15 2005
•		^		30. N. Wie an address of person who completed cause of death (Item 23a) (Type, Print)	1	Clown	1/1/5
		19		30. N. We an address of person who completed cause of death (Item 23a) (Type, Print) 2 3 0 3 WY RU F	allston	MAT	-104+
	e	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		7	
	3	Regist	rar	OCT 2 1 2005 Blown & parts			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ERVIN CARR 11:06 AM E OCTOBER a*00*5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMORE NORTHWEST HUSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month Day, Year Min. 7. Age (In yrs. last birthday)

9

Yrs. 5. Social Security Number Birthplace (State or Foreign Country) 213-32-9499 1**X**0 M 2□ F Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Baltimore MD 1 No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3326 21207 Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 📉 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) perviso 17. Father's Name (First, Middle, Last) 's Name (First, Middle, Maiden Sum 19b. Mailing Address (Street and Number or Rura Foute Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 1 Burial 2 Gremation 5 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final two weeks 3d. Date of delivery Month Day se contribute to the cause of death? 3 Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

BALTIMORE MUZIZOS

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If Item 27 is marked other ti
eny injury or other treumatic event, IIIs
ance.

Physician

/Medical

Examiner

Funeral

Director

ul Hygiene. Jother then "naturel", or Iteme 23a or 28a-f ehow vent, the Medical Examinar must be notitled at

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be ည

To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this funeral To the Funeral Director: completely filled in by the within 24 hours after To the Funerel Dire

disease or condition resulting in death)	Kespira	tory ra	lline			two was
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cesulting in death) Last	Due to (or as a conse	Ltome A	conved Pr	nevmonia	24	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 ☐Ectopic	pregnancy (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant conditions con			g cause given in Part I.			o the cause of death?
Diabetes Me	dutus			24a. Was an autopsy performe	ed? death?	utopsy findings availa completion of cause of
25. Was case referred to medical examiner?			26. Place of C	Death (Check only one)		
1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	Outpatient 3	DOA Other: 4 Nursing	Home 5 Residen	ce 6 □Other (Spe	ocify)
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, street, factify)	tory, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plation, in my opinion, death oc	ice, and due to the cau	se(s) and manner as a and place, and due	s stated. to the cause(s)
29b. Signature and title of certifier			29c. License number	290	I. Date signed (Mont	th, Day, Year)
I Wellah She	ue	1	445931	a	ctobor	20,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PIERCE

7220

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

borah

31. Date filed (Month, Day, Year) OCT 2 1 2005

PARICITETE HTS AVENUE

			1 - For State Registrar	State of Marylan	-	artment of I <i>tificate of</i>			giene Reg. No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Olivia Ellen Car	rter				2. Date of Dea Month Oct. 7	Day ⁶	2005	3. Simple plans [
Ì	Examin		4a. Facility Name (If not institution, give single 1941 1 Copley Road	Ē.		Balt	imore			ounty of Death	
	Funeral Director		5. Social Security Number 215-34-0851 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Apr. 1	3 , 1	923 Ma	ace (State or Foreign try) ryland
Maryland	find at	tor	10a. State 10b. County Maryland N/A		,Town or Lo					10	Od. Inside City Limits X☐ Yes 2☐ No
th with the	23a or 284 ast be not	Funeral Directo	10e. Street and Number 3411 Copley Roa	đ		10f. Zip Code 212	15		10g. Citize USA	en of What Count	try?
U K I K I J-0000	Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itsms 23a or 28a-f show any injury or other traumatic svant, the Medical Examiner must be notified at 200s.	by	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☼No If Yes, Give Year or Dates:	1	Was Decedent of fixes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		4. Race - America Black, White, e Specify: Bla	etc.
d within 72 ha	jiene. r then "natui tre Medicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) Years	(Give life.	dent's Usual Occu kind of work done DO NOT use retire Servi	during most of world)	P	alti ubli	of Business/Ind More C .c Scho	ity
	Mental Hygirked otherstic svent,	To Be C	17. Father's Name (First, Middle, Last) George W. Matthe	ws ews				ne (First, Middle, Miller		Gu <i>ma</i> me)	
, INIAL)	alth and to 27 is me		19a Informant's Name/Relationship (Type Marvin Matthews/	Brother	3411	Cople		Baltimo	re,	Maryla	nd 21215
Pages 1	tment of He tent: If Iter		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		emetery, crer	sition (Name of matory or other pla	nal Memo	13/05 orial P	k La	ation-City or To	m, State Maryland
D a	Deper Impor		21. Signature of Feneral Service License	reis	52	240 Rei	stersto	wn Rd B	alti	imore, M	eral Home d21215
/ ,	hysician by Medical xaminer transit tr	dicai Examiner	23a. Part1. Enter the disease, or complication of heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence of):	<u>GM</u>					Interval Between Onset and Death
The law requires that the death certificate	been signed by the ettending physishould be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnanc	y		23	3d. Date of delive Month	ry Day Year
ds, T.	signed by	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did to	· ·	,	e cause of death?
		Completed							an osy rmed? 2 2 No	24b. Were autop prior to con death? 1 \(\subseteq \text{Yes}	osy findings available inpletion of cause of 2 No
Of Vital	is certification	To Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatier	nt 3 DOA	hae	ath (Check only o		□Other (Specify	······································
TO HOL	eth. r: After this e funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	We	ıryat ork?]Yes 2 □No	28d. Describe h	now injury	occurred	
DIVISION	within 2 hospital of available within 2 hospital of a hosp	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str y)	reet, factory, office		28f. Location (S City or Tox		Number or Rura	l Route Number,
	n 24 hou n 24 hou se Funei	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.							
,	Nithi Com	Σ	29b. Signature and title of conflier	h		29c. Licer	se number		29d. Date	signed (Month,	Oay, Year)
λ			100 -1 - 10 0	impleted cause of death (Item	n 23a) (Type,	Print)	ourt 6	204201	Rai	21132	mi ALP
	St Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa		wills	001-1	- 24		×1133	

M			1 - For Amend Items 2	State of M	landanda	48en Ce	7/21/ tificat	osah e of L	B ^{alth} a Death	nd M		giene		5 3	3408	86
	Dhusisi		1. Decedent's Name (First, Middle, Last)								2. Date of Dea	ath Day	Ye	ar	3. Time of D	eath
	Physici /Medic		Brandon			Che					October				2258	М
	Examin	er	4a. Facility Name (If not institution, give s)				Location of	Death		4c.	County of D	eath		
			Johns Hopkins Hosp 5. Social Security Number 6. Sex		ge (In yrs. last	birthday)		timon	CE If Under 2	4 Hrs.	8. Date of Birt	h	NA	Righola	ce (State or I	Foreign
	Funeral Director			M 2□F	21	Yrs.	Months		Hours	Min.	(Month, Da)	v, Year)	3.	Country	Md.	-oreign
	Q		Usual Residence of Decedent								<u> </u>	0-1				
	arylar ehow	۲	10a. State 10b. County		10c. City, T									100	 Inside City Yes 2 	
	the M	ecto	Md. NA			Balt	imore					10a Citi	zen of What	Causta	21	
	with Ba or	ă	5223 Cedgate Rd.				101. 2.1	212	06			-	JSA	Country	y :	
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28e-f ehow Its Medical Exama ar must be matified at	by Funeral Director		2. Was Decedent	Ever in U.S.	13.	Was Dece	dent of His	spanic Orig	in? (Spe	cify Yes or No-		14. Race - A			
ဖွ	or Its	Ē	1 Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes 2X If Yes, Give		1	⊺Yes, spe 1 □ Yes		specify:	Puerto	Rican, etc.)		Black, W	/hite, etc	С.	
21215-0036	ural',	g p	3 Widowed 4 Divorced	Year or Dates:	-								Specify:	Bla		
15	"nat	Completed	15. Decedent's Edu (Specify only highest grade		1	(Give	dent's Usu: kind of wo DO NOT u	rk done d	urina most	of workii	ng	16b. Kir	nd of Busine	ss/Indu	stry	
12	filed withi Hygiene. other then	E	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)		rehou					Sı	per F	rock	,	
	e filed Il Hyg other	BeC	17. Father's Name (First, Middle, Last)		-				18. Mother	's Name	(First, Middle,			LESI		
/lar	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mannatic event.	To E	James	Leslie		Но	lmes,	Jr.	Re	obin	Re	nae		C	Cherry	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Iteme 23s or 28e-f ehow other traumatic event, the Medical Exam are must be calified at		19a. Informant's Name/Relationship (Ty)	oe, Print)	1		_				l Route Numbe			e, Zip C	ode)	
	l and lealth im 27 her tr		Robin R. Cherry	Mother	20b. Place			The second second	Rd.,		timore,			206	- 21-1	
or or	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	ceme	etery, crer	natory or c	other place	´ I				cation - City			
Baltimore,	artmer artmer ortant injury	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Α	Gr		ount		s of Facility		7-05		timor			
Ba	permit. Pages 1 and 2 a Department of Health ar Important: If item 27 le eny injury or other trau 906g.		A Onder	war	-				. East		Balti 1101	more E. N	, Md. Jorth	21 Ave.	.202	
			23a. Part1. Enter the disease, or compliant shock, or heart failure. List only or	cations that cause	ed the death. [Do not ent	er the mod	de of dying	, such as c	ardiac o				A	pproximate nterval Betwe	
	Physician		Immediate Cause (Final disease or condition	,	ensho	+ W	00111	11	of c	ho	< +			Ö	nset and De	ath
1	/Medical Examiner		resulting in death)		s a consequen						- 1					
	Lxammer	-	Sequentially list conditions,		s à consequent	ca ofi					10.00			-		
	ned ned	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00010 (01 40	3 ti 00/1304ti011	00 01).								1		
ć	execu in and ial-tra	Exa	that initiated events cresulting in death) Last	Due to (or as	s a consequen	ce of):								-		
8760,	cate be executed physician and the burial-transit	dicai														
9	leath certifica attending ph I for use as th	Med	IF FEMALE:	W 15												
Вох	attend attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	ath 3□	Ectopic pr					2	3d. Date of Month	delivery Da	ay Yea	ar
Ö	by the detached	Physician/Med	1 □Yes 2 □No 9 □Unknown	9□ Unknown	it time or deatr	1 5	Other (sp	өспу)			·					
<u>α</u>	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	by Ph	Part II. Other significant conditions con	tributing to death t	but not resultin	g in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco u	se contribute	to the	cause of dea	ath?
Records,	w requires been sign should be										1 🗆 Y	es 25	Ž(vo 3□	Probab	ly 4 ∏Uni	known
တ္တ	e law requ has been je 2 shouli	Completed									24a. Was a		24b. Were	autops	y findings av	ailable
Ě		mo.									perfor		death	?	□ No	SB 01
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					1 -		of Death	(Check only or					
d	. w =	٩	123,195 2010	ospital: 1 🔲 Inpati			t 3 DC		4 🗆 1401:		ne 5 Resid			pecify)		
n	ding After fune	i oi	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju	ay Year)	b. Time of Injury	≥yM 2	28c. Injury Work	es 2 N		8d. Describe h	ow injury	occurred /			
Division	Attending r death. ector: After by the fune	flca	3 Suicide 6 Could not be	28e. Place of In	ijury - At home	(0:30), farm, str					8f. Location (S	treet and	Number or	Rural F	Route Numbe	ar.
Ö	al or A after I Direct d in by	Certification:	4 Homicide determined	building, e	itc."(Specify)		treet				City or Tow alto.,M	n, State)	1600	B1k	Haven	wood
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	ician: To the best	t of my knowled	dge, death	occurred	at the time	e, date and	place, a	nd due to the o	ause(s)	Ave	as state	ed	
	the H in 24 the F	Medical	one)	and manner si	tated.	and/OF IN				OCCUFF				-		
	10 Vilt	Σ	29b. Signature and title of certifier	• 0 -	1		290	c. License OCM			2		signed (Mo			
•	(30. Name and address of person who co	Want	way			II De	nn CL	root	Do 1 to		ober,			01
	(4)		30. Name and address of person who co	inpleted cause of	death (Item 23	a) (Type,	Print) 1	ri re	IIII ot	reet	Dart	THOT.	e, FMI	ута	111 212	.J.
	Sta	te	31. Date filed (Month, Day, Year)		rar's Signature											
	Registr		OCT 2 1 2005		k has	de										

DHMH 17 Rev 1/2001

			For State Registrar		irtment of Health and It tificate of Death	nental Hygler Reg. I		34087
	Physici	an	Decedent's Name (First, Middle, Last)	1		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and	Carvella Inumber	4b. City, Town, or Location of Death		8 , 2005 4c. County of Death	1.42 AM
	Examin	er	Franklin Square		Rosedale		Ba I timor	00
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	8. Date of Birth (Month, Day, Yea	ar) 9. Birthpla	ace (State or Foreign
	Director		2/7 -16 - 4558 Usual Residence of Decedent	8 / Yrs.		Mugiust 28,	1924	MI)
	ryland how		10a. State 10b. County	10c. City, Town or Loc			10	d. Inside City Limits
	Ba-1 s	ctor	MD Baltimore	Midd	le River			1 ☐ Yes 2 ☑ No
	with the or 2	Dire	10e. Street and Number	1 21	10f. Zip Code	10g.	Citizen of What Countri USA	ry?
	death ms 23	Funeral Director		Decedent Ever in U.S. 13. V	2/220 Vas Decedent of Hispanic Origin? (Spirys, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America	ın Indian,
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other then "natural", or items 23e or 28e-1 show or other traumatic event, the Medical Examinational Learnaid at	by	1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never Ma	es 2 No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Specify: White, e	ite.
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade comple	ted) (Give i	lent's Usua! Occupation kind of work done during most of work	sing 16b.	. Kind of Business/Inde	ustry
2121	within iene.	mpi	Elementary/Secondary (0-12) Colle	ge (1-4or 5+) life. L	OO NOT use retired)		OWN F	tome.
	filed Hygie othar ant, II		17. Father's Name (First, Middle, Last)		Yomence L 18. Mother's Nam	ie (First, Middle, Maid		
/lan	should be and Mental is marked o sumatic eve	To Be	Lewis Bacigal 19a. Informant's Name/Relationship (Type, Print)	upa	Lore	Ha Lot	2	
Maryland	2 should and Men is marke sumatic				g Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip (Code) 2/220
	1 and 3 Health am 27 ther tra		FRANK J. Carvella,	TR50N 9/5		Date 20c.	Los tion - City or Tow	River, MID
Baltimore	Pages nent of I int: if it		1 Serial 2 ☐ Cremation 3 ☐ Removal 9 4 ☐ Donation 5 ☐ Other (Specify)	rom State cemetery, crem	natory or other place)	/	880	
altir	그 돈 돈 중		21. Signature of Funeral Service Licensee	1705F HOLU	Redeemed 10/2 Name and Address of Facility		Baltinoce	
Ö	permi Departiment Impo		Hater J. ask	6	2134 Willow	SDrine Ro	1 Home,	<i>P. M</i> . Z
Г			23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Oo not ente on each line.				Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Congestive	Cardiany	opath	4 /	Week
	Examiner		Du	e to (or as a opnsequence of):	A-le -	2/100	200	1011000
		ner	Sequentially list conditions, if any, leading to immediate Du	e to (or as a consequence	2149	11,500		De general
\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ecuter and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du					
,09	rcate be executed physician and s the burial-transit		bu	e to (or as a consequence of):				
68760,	rificate ng physi as the l	Aedicai	d					
Вох	eath cert attendin I for use	an/M	236. Was decedent pregnant	, outcome of pregnancy ive birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deliver	,
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months?		Other (specify)		Month E	Day Year
P.0	res that the de signed by the a be detached f	/ Ph	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
Records,	quires an sigr uld be	ed by	peripheral Ar	terral occle	usive bisego	1 □ Yes	2.☐No 3 ☐ Proba	bly 4 DUnknown
ooa	e law requii has been s je 2 should	Completed	Atrial tit	rillation		24a. Was an autopsy	24b. Were autop	sy findings available inpletion of cause of
E B	The cate h	Com	Diabetes	mellitus		performed	? death?	2□ No
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			th (Check only one)		
of	Phys or this sral dir	. To	1 195 2 A	1 ☐ Inpatient 2 ER/Outpatien Date of Injury (Month, Day Year) 28b. Time of Injury	t 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how in	6 ☐Other (Specify)	
ion	Attanding Party death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural ate)	Route Number,
	spital ours a neral C		29a. Certifier 1 Certifying Physician: T	o the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	a(s) and manner as etc	itad
	na Hos n 24 h na Fur pletely	Medical	(Check only 2 Medical Exeminer: On t	he basis of examination and/or inv manner stated.	vestigation, in my opinion, death occur	red at the time, date a	and place, and due to t	the cause(s)
	To tl To tl comp	×	29b. Signature and title of certifier	D-0.	29c. License number		Date signed (Month, D	Day, Year)
•	1-6		Mn.		H 35593	S DO	C+ 18 2	L002
	り		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print) a ce Aue:	Baltime	DR. MD	2/22/
	Sta			32 Registrar's Signature				,
	Regist	rar	DET 2 1 2005	to ann At Mas	ala)			

					State of Ma	nulan	d / Dens	rtmoi	at of H	aalth a	and M	ental Hy	aiono	_09.5.0.		
			For State		State of Mic	ai ytai i			te of E			,	-	1000	0100	
	-		Registrar	(First, Middle, Last)			061	unca	ie oi L	Jeani		2. Date of De	Reg. No.	CUU	3408	3.8-
3	Physici	an		Doreen (ombe							Month	Day	Year	- 3-38	Дм
	/Medic	_		not institution, give s			4	4h City	, Town, or	Location	of Death	10	1 dc	County of De	3 0 ° 30	Π
	Examin	er	ECO DE	In Sal	120	tos	D. tal	RE	1000	100	Dealli		Be		mare	
46	Funeral	-	5. Social Security No		7. Ag	e (In yrs.	last birthday)	If Unde	er 1 Year	If Under	24 Hrs.	8. Date of Bir	th		irthplace (State or Fo	oreian
754	Director		212-42-0	265	M 2⊠F	59	Yrs.	Months	Days	Hours	Min.	(Month, Da 11/14/	1945		aryland	
	P _		Usual Residence of													
	show	<u>.</u>	10a. State	10b. County N/A			y, Town or Lo								10d. Inside City L	
	8a-f	octo				INO	ttingh								M∑Yes 2[
	with th	Dire	7705 Win	dy Ridge				10f. Z	p Code	36-44	/. 1 /.		10g. Citi.	zen of What (-	
	72 hours after death with the Maryland natural; or items 23e or 28e-f show strait frammer must be notified at	by Funeral Director		-	2. Was Decedent	Constant	C 42.1	W 0				-4		U.S.A		
	ter d	Ę.	11. Marital Status	ed 20 Married	Armed Forces?		.3.	f Yes, sp	ecify Cubar	n, Mexicar	n, Puerto	cify Yes or No Rican, etc.)	-	Black, Wh	nerican Indian, nite, etc.	
936	urs al	by	3 Widowed		If Yes, Give Year or Dates:			1 🗆 Yes	20 No	Specify:				Specify:	White	
21215-0036	2 ho	ted	(6	15. Decedent's Educ	ation		16a. Dece	dent's Us	uai Docupa	ition	(16b. Ki	nd of Busines	s/Industry	
75	within 7 ene. then "r	pie	Elementary/Secor	ify only highest grade ndary (0-12)	College (1-4or 5	i+)	life.	DO NOT	ork done d use retired)	uring mos	it of worki	ng				
	filed wi Hygien other th	Completed	12				Lab	Tech	nicia				-	crobio	logist	
_p	be file ital Hy od oth eveni	Be	17. Father's Name (-11							(First, Middle		,		
Ma	should I and Men marke umatic	2		alter New								Hocke				
Maryland	2 sh and is m			me/Relationship <i>(Ty)</i> mbs/Husbai								Route Numb				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hydiene. Depertment of Health and Mental Hydiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f show my highly or other treumatic event, the Medical Examinar must be notified at once.				ıu	20h B	7 / U.S Place of Dispo		and the Contract	age r		ngnam,			21236-4414	4
Baltimore,	if it of the or of or of			☐Cremation 3 ☐Re	emoval from State	0	emetery, crer	natory or	other place					-	or Town, State	
Ħ	t. Pa ntmen ntant			5 Other (Specify)		Ga	rdens		_		10/22				, Maryland	
Bal	Depe Impo Impo Indo		21. Signature of Full	neral Service License	1										al Home, 1 ad 21206	Lnc.
			23a Part1 Enter th	na disease or compli	ation that rauson	I the deat								nai yiai	Approximate	
E 30	JA,		shock, or hear Immediate Cause (ne disease, or complie t failure. List only on	e cause on each li	10		01 (110 1110	ao or aying	, 5001, 05	-	r respiratory a	11651,		Interval Betwee	
k_{ij}	Physician /Medical		disease or condition resulting in death)	a a		rd	rac	a	rre	ST						
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	e death he atten ied for u	sici	in the past 12 1 Yes 2		4☐ Pregnant at 9☐ Unknown	time of d		Other (s						Month	Day Yea	ır
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uc	fe fe	ion	Natural	5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	28c. Injury Work	ai :? ∕es 2.∐		28d. Describe	now injur	y occurred		
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_	To the Hospitel or Attendi within 24 hours efter deeth. To the Funerel Director: A completely filled in by the fu		29a. Certifier	Cartifying Phys	ician: To the best	of my kno	wledge, deat	n occurre	d at the tim	e. date ar	nd place.	and due to the	cause(s)	and manner	as stated	
	• Ho 1 24 h • Fui letely	edicai	(Check only one)	21 Medical Examin	ner: On the basis o	t examına	ition and/or in	vestigatio	n, in my op	oinion, dea	ath occurr	ed at the time,	date and	place, and d	ue to the cause(s)	
	To the transfer of the transfer of the transfer of tra	Me	29b. Signature and	title of certifier				25	C License	number	1	/_	29d. Dat	e/signed (Mo	nth, Day, Year)	
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-	24		30. Name addr	ess of person who co	mpleted cause of c	leath (Iten	п 23а) (Туре,	Print)			۵ ۵ ۵	1	•			
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	Sta		31. Date filed (Mon.	th, Day, Year)	32. Registr	ar's Signa	ature)	
	Regist	rar	DOT	9 1 2005	Me	21	Same	8/ 1								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiens 1 - For Stete Registre Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EMMETT /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death c. County of Death 9004 HINTON AVE. ISLAND 7. Age (In yrs. last birthday) 49 Yrs. If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Social Security Number 9. Birthplace (State or Foreign Country)

MARYLAND **Funeral** 100 M 2□ F Days 216-62-9632 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits directions be notified at BALTIMORE Be Completed by Funeral Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 23a 12. Was Decedent Ever in U.S. Armed Forces? or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: L Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Pages 1 and 2 should be filed within 72 hours at ment of Heath and Mehalel Hygiene.
ant: if Item 27 is marked other than "natural, on ury or other traumatic event, the Medical Exar. Specify: 3 Widowed 4 Divorced HITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME BUILDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, STEPHANIE 20a. Method of Disposition 9004 HINTON AVE. MILLERS ISLAND MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 Scremation 3 □ Removal from State BAYVIEW CREMATORY 10 permit. Pag Department Important: f any injury o ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Further Service Licens 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disease, o complications that eaused the shock, or heart failure. List only one cause on each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain /4 mor Pnysician 1 year /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical attending physic I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2/Q No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation s effer deu. 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024356 October 20 Chaler 10 9103 Franklin Sa Da 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) WATERFIELDIMO 1 more 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 1 2005 Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

	•	1- State of Maryland / Department of Health and Mental Hygien 0 0 5 3 4 0 9 1
Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 10 12 30 P M
/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8512 Haccis Hye 8ACTIMORE 8ACTIMORE
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Younger 1 Year 1 Younger 24 Hrs. Nonths Days Hours Min. 9. Birthplace (State or Foreign Country) Months Days Hours Min. 9. Birthplace (State or Foreign Country) MARYCAND
tryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show mast be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
r death w tams 23s	Ineral	11. Marital Status 12. Was Decedent Ever in U.S. Angued Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 14. Race - American Indian, Black, White, etc.
5-UU36 72 hours after natural; or its	by	1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give 1 Year or Dates: 1 Yes 2 No Specify: Specify: Specify: White
within within then then then then then then then the	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Yland Z could be filed I Menta! Hygic varked other natic avent, I	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)
Mary d 2 shou th and M 27 Is mar traumat	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimo permit. Pag Department Importent: I any injury o		14 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility BATI MORE, MD 21234 EVANS FUNERAL CHAPEL 8800 HARFORD ED.
		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Pnysician /Medical Examiner		disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
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OX 6	ian/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy
. 0 00	Physicia	In the past 12 months? 4 Pregnant at time of death 5 Other (specify)
Records, P.O The law requires that the te has been signed by th	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
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DIVISION SITE OF Attenurs after deat or after deat or after deat or after deat or after or af		4 Homicide determined determined building, etc. (Specify)
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71		MIN/2/Chr D23829 10/17/60
		30 ramound agdress of porson who completed cause of death (Item 23a) (Type, Print) Albert F Delos Vegy mo 515 Fair mount Are Towson, Mc 21286 31. Date filed (Month, Day, Year) OCT 2 1 2005 Registrar's Signature
	ate	OCT 2 1 2005 Bearing & Space

at 10:35 AM October 18, 2005
Baltimore, Maryland 21215-0036 FRASCA, DOMINIC DIVISION of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Mide	dle, Last)	State of Maryla er dvr G848					2. Date of Month	Death	20	005 Year	3. Time of I
sician edical	Domini	cT.	Frasca						ober			10:3
miner	4a. Facility Name (If not instituti	on, give str	eet and number)		4b. Cit	y, Town, or Locat	tion of Death		4	lc. County o	f Death	
	Stella MAr					Towso				altin		
al	5. Social Security Number	6. Sex	7. Age (In)	rrs. last birthda	Months		ors Min.		Day, Yea	ir)	9. Birthp	lace (State or Try) land
or	215-16-6010 Usual Residence of Decedent	-		82 113				Jan 9	9,19	23	Mai	yrand
	10a. State 10b. Coun	•		City, Town or	Location						1	0d. Inside City
by Funeral Director	MD Balt	imore	e	Ba	ltimo	ore						1 ☐ Yes
Director	10e. Street and Number				10f. Z	ip Code			10g. C	Citizen of Wi	hat Coun	itry?
	7256 Bridg	ewood	d Drive			21224			U	SA		
Funeral	11. Marital Status	12	. Was Decedent Ever i Armed Forces?	n U.S. 1	3. Was Dec	edent of Hispania ecify Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or Rican, etc.)	No-		- Americ	an Indian, etc.
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Be C	- 1 -						achel	,			,	
5	19a, Informant's Name/Relation		a. Print)	19b. M	ailing Addre	ss (Street and Nu					State Zin	Code)
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		For State Registrar	State of Ma	aryland /		rtment of F		, ,	ene	5	340	93
Physic	vian	1. Decedent's Name (First, Middle	, Last)					2. Date of Death	Day	Year _	3. Time of C	
/Med		MACE	NEWTON	F	OXWE		1	October		005	0540) M
Exami	iner	4a. Facility Name (If not institution, PM/154/A	NAM MEDICA	4 CAN.	W	ب أ	r Location of Death		4c. County o	1/8/11	1100	
Funeral Director		5. Social Security Number 220–28–0768	6. Sex 7. Ag. 1 X M 2 ☐ F	e (In yrs. last t	Yrs.	If Under 1 Year Months Days	If Under 24 Afs. Hours Min.	8. Date of Birth (Month, Day, August 3	rear)	Cour	olace (State or otry) Cyland	Foreign
land		Usual Residence of Decedent 10a. Slate 10b. County		10c. City, To	wn or Loc	cation				1	0d. Inside City	y Limits
Mary	tor	Maryland Some	erset			Cr	isfield				1 🗆 Yes	2 💢 No
th the	Director	10e. Street and Number				10f. Zip Code		10	og. Citizen of W	hat Cour	itry?	
eth w		27074 St. Pete				1	21817		US			
item item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- Ameno , White,	etc.	
I E, IMAN YIMING KIES INCOMES after deeth with the Maryland I health and Mental Hygiene. Thealth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Wedical Exaction or market collised at	þ	3 Widowed 4 Divorced	ed 1 X Yes 2 1 Il Yes, Give Year or Dates:	1963	1	☐ Yes 2XNo	Specify:		Specify:	Whit	ie .	
72 ho	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16	(Give i	ent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Bus	siness/In	dustry	
within sne.	m	Elementary/Secondary (0-12)	College (1-4or 5	5+)	iife. L	OFF:			Employ	men	t Secur	rity
Hygie Ther		12 17. Father's Name (First, Middle,				Office	Manager 18. Mother's Nan	ne (First, Middle, M			1011	
Aental Aental rked	To Be	Lennie Foxwel	1				Nora	Ewell				
2 should be and Mental is marked can		19a. Informant's Name/Relations		1:	9b. Mailin	g Address (Street		ıral Route Number,	City or Town, S	State, Zip	Code)	
and and lealth m 27 her tr		Judy Long Foxt	vell (Wife)			Box 829 - (sition (Name of	risfield,	Maryland 2		Oib. as T	Ctata	
parmit. Pages 1 and 2 Department of Health a importent: if item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	ceme	tery, crem	natory or other pla	10000		20c. Location - (029
artme		4 □Donation 5 ☑ Other (S		Doman	ster 1	Memorial Pa . Name and Addre	ank Octobe ass of Facility _	r 21, 2015	Cambrid	ige,i	larylar	ð
Depa Depa impo impo		Malypoot	Traishaw-Iru	THE				neral Hon Crisfield		017		
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused		o not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	1017	Approximate Interval Betw	reen
Pnysician		Immediate Cause (Final disease or condition	ant	20102	clu	ota Co	ndioure	when Dis	sease		Onset and D	eath
/Medica Examine		resulting in death)	Due to (or as	a consequenc	ce of):							
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a consequenc	ce of):					-		
cuted nd ransit	Examiner	that initiated events	С									
be exercisen ar		resulting in death) Last	Due to (or as	a consequenc	ce ol):							
cate b physic physic the b	dical		d									
OX O h certifi ending	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date	ol deliv	erv	
w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	hysician/M	in the past 12 months?	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnancy Other (specify)	у		Mon	ith	Day Y	'ear
d by the	Phy	9 Unknown Part II. Other significant condition		out not regulling	g in the ur	adarhina cauco cir	van in Part I	23e Did tob	pacco use contri	ibute lo t	he cause of de	eath?
w requires the second signer should be d	d by		4	seus e	•	idenying cause giv	on mranti.		_		pably 4 □U	
law requas been as been 2 shou	Completed	7						24a. Was a		Vere auto	ppsy findings a	available
VICAL MEC vicion: The lav certificate has rector, page 2	E O							autops perform	y ned? d	rior to co eath?	mpletion of ca 2□ No	tuse ol
ysicien: The ysicien: The is certificate hi director, page	Be C	25. Was case relerred to medica examiner?					26. Place of Dea	ath (Check only on			20110	
d is	ုင	1 ☐ Yes 2 No	Hospital:		Outpatien	1 3 00 N		lome 5 Reside			<i>'y)</i>	
OII C	in oi	27. Manner of Death 1 Abatural 5 Pendir 2 Accident investi		iry Year) 28t	b. Time of Injury	Wo	ryal rk?]Yes 2 ⊡No	28d. Describe ho	w injury occurre	ed		
INISION or Attending after death. Director: After	ertification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	jury - At home	, larm, str	eet, factory, office		28l. Location (St		or Rura	3/ Route Numl	ber,
tel or rs afte ei Dire	Cert	4 Homicide	bullding, e	tc. (Specify)				City or Town	i, State)	.,		
UIVISION OF To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	29a. Certifier 12 Certifyir (Check only one)	ng Physician: To the best Examiner: On the basis of and manner st)
To the To the complet	M	29b. Signature and title of certifie	10			29c. Licens	se number	2	9d. Date signed	(Month,	Day, Year)	
*		/aul f	Hully			22	4812		10/18	105	2	
20		30 Name and address of person	who completed cause of e	death (Item 23	a) (Type,	Print) Th ST	Poco	urred at the time, di	24g M	2	185,	
32765345	State	31. Date liled (Month, Day, Year,	32 Regisl	rar's Signature	do	arte						
Regis	strar	OCT 2	L 2005	as so	1							

220-28-0768

MACE N. FOXWELL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend item #10b Per FH G848 Polytoga 1850 (pack) 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** COLUMBUS /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. Month, Day. BUL 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□ F 215-07-7572 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or other treumatic event, the Medical Exerciner must be notified at Anne Arundel 1 Yes 2 No Completed by Funeral Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? NECK 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "na any injury or other treumatic event, It a Medic once. College (1-4or 5+) Elementary/Secondary (0-12) 7 + HGRADE Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ပ THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (DAUGHTER) GLEN BURNE MD. 21060 20c. Location - City or Town, State IVONNE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. REST CEMETERY 10-24-05 HANOVER MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL 21. Sign ture of Funeral Service Licensee 40 N. FULTON AVE. BALTO, MD. 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLON CARCINOMA Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ BEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed ERTENS 10N 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) fillad in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S. DHARMASTER, MO. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien State Amend Item#13 per FH G848 10/21/Pricate of Death 34095 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBEC **Physician** 7:44 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH MARY MEDICAL TOWSON If Under 1 Year | If Under 24 Hrs. | 8 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2□F Director Yrs -16-16/8 ana Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at Funeral Director Timor 1 Yes 2 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a filed within 72 hours after death Decedent Ever in U.S. Was Dec Appled Fo 1 Yes Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes, Give Year or Dates: WWI es Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "na eny injury or other treumatic event, Ins Made once. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code 20a. Method of Disposition 20b. Place of Disposition cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shature Fuyeral Service Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ipplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death HEMORRHAGE CEREBRAL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed iding physicien and Due to (or as a consequence of). P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by i Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 1 🗌 Yes 2 0 No 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospitei within 24 hours a 1) Certifying Physician: To the best of my k 29a, Certifier owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai aminer: On the basis of exan investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the ated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 42736 X npleted cause who co death (em 23a) (Type, Print) 21204 OSLER DRIVE 7601 MD MAN MARYLAND 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 2 1 Registrar 2005

State of Maryland / Department of Health and Mental Hygien 34096 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Μ. Grumschlis October 17, 2005 12:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 201-26-8973 Yrs. Feb 24, 1936 69 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County or 28a-f show 10d, Inside City Limits The Medical Exerciper must be notified at Director MD 1 ☐ Yes 2 No Baltimore Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? items 23a 2906 Aspen Hill Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☒ No Specify Specify: White δ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Kanjorski Stella (Unavailable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie any injury or other trau once. Stephanie Harris (Daughter) 2906 Aspen Hill Rd. Baltimore, MD 21234 20a. Method of Disposition

Method of Disposition

3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Burial Pk 10/20/05 South Brunswick, NJ 21. Signature / Funeral Service Licensee 22. Name and Address of Facility M.J. Murphy Funeral Home Men 616 Ridge Rd. @ New Rd. Monmouth Junction, NJ 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE /Medical Due to (or as a consequence of) Examiner Sequentially that conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy signed by the atte Month Day 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 ☐ No Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 2 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No death the Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dulaney Valley Rd. 2300 MAHMOOD 32/Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 18, 2005 Physician Agnes Μ. Getz 2:49 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Home Baltimore Essex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 85 217-09-1280 Yrs. Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e or 1300 Windlass Drive 21220 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: White 3 XWidowed 4 ☐ Divorced "naturel" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Western Electric 7th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil timent of Health and Mental Hent: If Item 27 is marked ott jury or other treumatic even Alfred Lookingland Della (surname unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. A. Virginia Koerner (dahtr) 50 Pinehurst Road, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. Meadowridge Mem'l Park 10/21/05 Elkridge. Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livers 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 1 NO 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral I o the Hospitel 1 Exeminer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tife of certifier 29d. Date signed (Month, Day, Year) 10-20-2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD. WASBAM EASTERN MD-2122 70 31. Date filed (Month . Registrar's Signature 1 2005 State Registrar

		•	For St - Stee Registrar	ate of Marylan		artment of I		nd Mental I	Hygiene	2000	31.000
	Physici	an	Decedent's Name (First, Middle, Last)		-			2. Date o	f Death		3. Time of Death
	/Medic	al	Fred Dennis Gatrel			4b. City, Town,	as Logation of	Octob	er <u>1</u> 8	2005	6:24 P M
	Examin	ier	4a. Facility Name (If not institution, give stree Frederick Memorial H			Frederi		Death	40	: County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i		If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date o	fBirth Darn Yean	0.0:	rthplace (State or Foreign
. A	Director-		214-30-1949 1XI M Usual Residence of Decedent	2□F 71	Yrs.			July	29 Yea1	934	Maryland
	yland		10a. State 10b. County		y, Town or Lo						10d. Inside City Limits
	e Mar	Director	Maryland Freder	ick		Jeffer	son				1 XYes 2 □ No
	death with the Maryland ms 23a or 28a-f ehow r must be notified at		10e. Street and Number 3742 Jefferson Pike			10f. Zip Code 2175	5		10g. Ci	tizen of What C	ountry?
	d within 72 hours after death with the Marylan speed. The with the heatrail, or items 23e or 28e-1 ehow the Madical Exeminer mast be notified at	by Funeral	1 Never Married 2 Married 1	vas Decedent Ever in U. med Forces? XIYes 2□NDEC Yes, Give Yes, Give Year or Daes NOV.	1906	Was Decedent of f Yes, specify Cub □ Yes 2€ No		in? (Specify Yes o Puerto Rican, etc.	r No-	14. Race - Am Black, Wh Specify: V	
2	72 ho	eted	15. Decedent's Educatio (Specify only highest grade cor		16a. Deced	lent's Usual Occu	pation during most of	of working	16b. H	(ind of Business	s/Industry
2	within then " to Med	Completed		College (1-4or 5+)		kind of work done 00 NOT use retire nic Engi		- nog	Doir	Dietz	ibution Co
N	tal Hygie od other I	ပိ	17. Father's Name (First, Middle, Last)		riectia	HIC ENGL		's Name (First, Mic		-	ibution Co.
land	uld be Aental rrked c	To Be	John Gatrell				Nann	ie Writt			
	ind 2 should alth and Men 27 ts marke or traumatic		19a. Informant's Name/Relationship (<i>Type</i> , F Betty Jane Gatrell/W					or Rural Route No. , Jeffers			
altimore,	mit. Pages 1 and artment of Healt ortent: If item 2 injury or other 2		20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Res	lace of Dispo Thaven	sition (Name of natory of other pla MEMOLIA	T Gard	ens Oct.	21, 2	ocation - City o 2005 Fr	r Town, State cederick, MD.
Balt	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licensed	ashar IM	021 1	Name and Addr Keeney &	Basfo	rd Funera Street,	al Hom	ne Arick N	n 21701
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death	h. Do not ent	er the mode of dy	ing, such as c	ardiac or respirato	ry arrest,	LICK	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	VENTRICE	ICAR	FIBR	ichn	CN			Onset and Death ZY NRS
	/Medical Examiner		resulting in death)	Due to (or as a consequence				cuchr	Mico	A==	1515 255
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		CNIZA	11001170	LUCKIE	UDE	1176	MANY JEHRS
· _	ecuted and I-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
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õ ×	eath certifica ettending ph for use as t	10	IF FEMALE: 23c II	yes, outcome of pregna	incv						
ň	eath etter for u	Physician/Me	in the past 12 months?	Live birth 2 Fetal Pregnant at time of de	Ideath 3	Ectopic pregnand Other (specify)	СУ			23d. Date of de Month	Day Year
7	w requires thet the de been signed by the should be detached	by Ph	Part II. Other significant conditions contribu	iting to death but not resi	ulting in the u	nderlying cause g	ven in Part I.	23e. [Did tobacco	use contribute t	to the cause of death?
suga	equire; en sig ould by	ted b	END STREE RE	WR DITE	MIE			-	I∐Yes 2	. □No 3 □ P	robably 4 Unknown
Vital Records,	The law requires ite has been sign age 2 should be	Completed						a	Was an autopsy	prior to	utopsy findings available completion of cause of
a		e Cor	05. W					1 U Y		death? 1 ☐ Ye	s 2□No
	nysician: nis certifica director, I	0 8	25. Was case referred to medical examiner? 1 \(\sum \) Yes \(2 \sum \) No	tal: 1 Inpatient 2	ER/Outpatien	t 3□ DOA O	hor	of Death Check of Sing Home 5 1		6 □Other (So.	acity)
Division of	fing Pt	tlon: T	27. Manner of Death 1 Natural 5 Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Descr	ibe how inju		ocity)
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۵	pitei or ours afte eret Din filled in I		29a. Certifying Physicie				ima data and				
	To the Hospitei or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examiner:	On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death	n occurred at the ti	me, date an	d place, and du	s stated. e to the cause(s)
)	with To To To To To To To To To To To To To	Σ	29b. Signature and titld of certifier	law M	0.	1	1) 166	75	1	ate signed (Mon	1, 2005
	h,		30. Name and address of person who comple	cause of death (Item	п 23а) Туре,						
100	1_/		31. Date filed (Month, Day, Year)	Cause of death (Item	12 12	MNSWIO	K V	10 2	1116		
	Sta Regist	-	OCT 2 1 2005	Brarya	K A	nede					

		1 - State Registrar	tate of Marylan		artment of the trificate of			iene	005	34.100
Physic	ian	Decedent's Name (First, Middle, Last)	DI TENDEMU	GODGI			2. Date of Deal Month DCTDBEI	th	20්ශී්5	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give street Saint Joseph Med	ELIZABETH et and number) dical Cent			or Location of Dea	th	4c. Cou	nty of Death Balti	11:20 AM
Funeral Director		211-12-1191	7. Age (In yrs. 2 ☐ F		If Under 1 Year Months Days		. (Month, Day	Year) 1923	Cour	place (State or Foreign htry)
aryland		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo					1	10d. Inside City Limits
h the Mi	Director	MD CARROLL 10e. Street and Number	WI	ESTMIN	10f. Zip Code		1	0g. Citizen (of What Cour	1 ☐ Yes 2√ No ntry?
ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or Iteme 23a or 28e-f show event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married	RD. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		211 Was Decedent of I I Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	В	Race - Americ Black, White, c <i>ify:</i> WHI	etc.
21215-0036 d within 72 hours after gjene. or then "naturel", or Ite	Completed		College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	prking	16b. Kind of	Business/In	dustry
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	L _o	LEWIS 19a. Informant's Name/Relationship (Type,	S A. MYERS		na Address (Street	EDN	VA Tural Route Number		RBER	Code)
C = 01 L		E. PHYLLIS MYERS	-DAUGHTER	440	GROVE L		ESTMINST			,
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rem A ☐ Donation 5 ☐ Other (Specify)	oval from State	emetery, crer	sition (Name of natory or other pla TITHED A N		Date 0/22/05		in - City or To	
Baltimo permit. Pag Department Important: I eny injury o		21. Ignal A CPune Service Licensee	ININ	22	. Name and Addre	ess of Facility FI	LETCHER	FUNE	RAL H	OME
		23a. Part1. Enter the disease, or complicate shock, or beart failure. List only one commediate Cause (Final	ause on each line.	h. Do not ent	er the mode of dy	ng, such as cardia	WESTMIN		, MD.	Approximate Interval Between Onset and Death
Physician care be executed by sician and physician and physician and the bruil-transit	dicai Examiner	resulting in death)	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of): PRTERY uence of):						YEARS
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dS, P.O. I	ρ	Part II. Other significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tot			ne cause of death?
	Completed						24a. Was a autops perform	n 241	b. Were auto prior to cor death?	psy findings available inpletion of cause of
Division of Vital Reference to the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate the completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner? 1	oital: 1 Inpatient 2 Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju Wo	ner: 4 ☐ Nursing	ath (Check only on Home 5 - Reside 28d. Describe ho	nce 6 🗆 C		v)
Division To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the to	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (St. City or Town		mber or Rura	il Route Number,
To the Hospital or A within 24 hours effer To the Funeral Directompletely filled in by	Medicai (29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	an: To the best of my kno On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the ti	me, date and plac opinion, death occ	e, and due to the ca urred at the time, da	use(s) and ate and place	manner as st e, and due to	ated. the cause(s)
To the within To the comp	W	29b. Signature and title of certifier	alv J.	Helen	29c. Licens	se number 7695	1		ned (Month,	
6		30. Name and address of person who comp	·		Print) ISLER DF	RIVE TO	WSON. ME	RYLA	ND 21	204
St. Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 1 200	32. Registrar's Signa	iture	mode					

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			1 - For State Registrar	State of Maryla		nent of Health and		2005	34101
	Physici /Medi		1. Decedent's Name (First, Middle, La TYR ONE	HOLMES	SK		2. Date of Death Month	Day Year	3. Time of Death
	Examir Funeral Director			ford NSq.4Re	s. last birthday) If I	City, Town, or Location of De. Baltyo Judger 1 Year If Under 24 Hi	ath S. 8. Date of Birth	4c. County of Deat A 9. Birt	hplace (State or Foreign unity)
	ith the Maryland or 28e-f show	ctor	Mary and NA	10c. (Saltin	nore			10d. Inside City Limits 1 XYes 2 □ No
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or itams 23e or 28e-f show any injury or other traumatic avant, the Medical Evant art must be retilled and once.	d by Funeral Director	10e. Street and Number 14 S. Castle 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates:	U.S. 13. Was I	of. Zip Code 2/23/ Decedent of Hispanic Origin? , specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame Black, White	rican Indian,
21215-0	within 72 he ene. than *natu he Medical	Completed by	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's (Give kind life. DO N	Usual Occupation of work done during most of w OT use retired)	orking 16	b. Kind of Business/	ndustry
Maryland 21	2 should be filed withi and Mental Hygiene. is markad other than aumatic avant, Ite M	To Be Cor	17. Father's Name (First, Middle, Las	tolmes	Sanita	18. Mother's N	ame (First, Middle, Ma	iden Sumame)	iTy
	1 and 2 should Health and Men Iem 27 is marka		19a. Informant's Name/Relationship MS. Angela E	Typo, Print) (Laughte Vans	_14 S.J	dress (Street and Number or I	Rural Route Number, C	City or Town, State, 2	ip Code) 2/23/
Baltimore,	Pages 1 anent of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Cremation 3 Other (Special Control of	Removal from State	Place of Disposition cometery, cremator,	(Name of or other place)		c. Location - City or	Fown, State
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Sergice Lice		22. Nar	ph L. Russ W. North Au	Funeral Balto. Ma	Horne, P.A 1. 21216	
	Physician /Medical		23a. Pahl. Enter the disease, or con stock, or heart/failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the de one cause on each line. a		mode of dying, such as cardi	ac or respiratory arrest	t,	Approximate Intervat Between Onset and Death
	rate be executed whysician and purial-transit the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse					
O. Box 68760	t the death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	ital death 3 ⊟Ecto	pic pregnancy or (specify)		23d. Date of deli	very Day Year
rds, P.	w requires that been signed I should be det	by	Part II. Dther significant conditions	contributing to death but not re	esulting in the underly	ing cause given in Part I.		cco use contribute to 2 □ No 3 □ Pro	/
	iù cc	Completed					24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3	Other:	eath (Check only one)	C COther (Core	14.1
	ding h. After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how		ny)
Division		Certification:	3 ☐ Suicide 6 ☐ Could not to determined	building, etc. (Spec	city)		City or Town, S		
	To the Hospite within 24 hours To the Funaral completely filled	edical	29a. Certifier (Check only one) 2 Medical Exa	nysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, death occu nation and/or investig	rred at the time, date and place ation, in my opinion, death occ	e, and due to the caus curred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier			29c. License number 057727	29d.	Date signed (Month)	Day, Year)
	1		30. Name and address of person who	eampleted cause of death (Ite	em 23a) (Type, Print)	het Place	A. 1	1/2 0/5	21227
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegiştrar's Sigi			- rundo	W- 711)	10166

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 Kathryn Lounsbery Hutchings October 16 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Hospitalof Baltmore sinal 5. Social Security Number 6. Sex if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1 M 250 91 Hours Min. 121-07-8989 Director 10-21-1913 New York Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1238 € 5400 Vantage Point Rd. 21044 USA death Items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. filed within 72 hours after Yes 2 XNo
f Yes, Give 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed by permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!", any injury or other traumatic event, the Medical Exagnos. 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lounsberv Anne Thomas Lounsbery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Central Park West NY, NY 10024 Peter Hutchings/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 GCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10-20-2005 Beltsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave Silver Spring MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 days /Medical Due to (or as a consequence of): Examiner thicillin-resistant Staph avreus bacterenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death signed by the at Id be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Complete autopsy performs hypertension, hypothyroidism certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ۵ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Diractor: After th within 24 hours after To the Funeral Dira

Kathryn

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)

Antra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2005

DН HARLES HAHN 5-7034 Phys /Me

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1. Decedent's Name (First, Middle		77 1						2. Date of I		·6, 2	2005	3. Time of 1447	
ian cal			Hahn		4b. City, Tow	um orloa	cation of		OCTODI			y of Death		p '
er	4a. Facility Name (If not institution BALTIMORE WASHI	_		ביויאם	GLEN B			Dealii				ARUN		
	5. Social Security Number	6. Sex		rs. last birthday) If Under 1 Y	Year III	Under 2		8. Date of E	Rinth		9. Birth	place (State	or Foreig
	368-84-3769	1 X M 2□ F	2	.7 Yrs.	Months Da	Days H	lours	Min.	Jan.	5, 19	78	Mis	ssouri	
	Usual Residence of Decedent		100	City, Town or L	conting								10d. Inside 0	ity Limit
7	10a. State 10b. County	. 1 1		,,										2 N
Funeral Director		Arundel_	Cu	rtis B	ay	nde				10g. Ci	itizen of	What Cou	intry?	
<u></u>	10e. Street and Number Gardenview 7120 Crandview				2122					11.	.s.A			
era	11. Marital Status	12. Was D	ecedent Ever in	U.S. 13	. Was Decedent	nt of Hispan	nic Orig	in? (Spe	cify Yes or I	1	14. Rac	ce - Ameri	ican Indian,	
Ĭ	1 ☐ Never Married 2 ☒ Marr		Forces?		Il Yes, specify to 1 ☐ Yes 2 🕅		Specify:	Puerto	nican, etc.)			ick, White,	, вкс.	
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Completed	Elementary/Secondary (0-12)	Colleg 5-	e (1-4or 5+) L		Security					U.S	5. G	overn	nment	
000	17. Father's Name (First, Middle,				Decar I e	- -	. Mother	's Name	(First, Mida	lie, Maidei	n Sumar	me)		
ă		in					Reb	beco	a Mar	ie Fl	Letc	her		
_	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mai	iling Address (St	Street and	Number	r or Rura	l Route Nun	nber, City	or Town	, State, Zi	ip Code)	
	Patricia Kay H	lahn (Wii	Ee)		Grandy:									
	20a. Method of Disposition	0 (D	206	. Place of Disp cemetery, cr	position (Name of rematory or other	of er place)	1	D	ate	20c. L	ocation	- City or T	own, State	
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		om State		apel Cer		ry 1	0/22	2/05	Tro	оу, 1	MI		
	21. Signature of Funeral Service	Licensee			22. Name and A	Address of	Facility	nors	1 Hom	_				
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ler	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Dila	at caused the doneach line. ated car to (or as a cons	dionyo	inter the mode of								Approxima Interval Be Onset and	tween
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year ROBERT LEE HUGLEY 8:35 AM Oct 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5004 PLAINFIELD AVE. BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 (XM 2 □ F 419-34-3067 Yrs. Director 76 Jan 21, 1929 **ALÁBAMA** Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location or 28a-f show 10d, Inside City Limits treumatic event, the Medical Examiner must be notified at MD Director 1 X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5004 PLAINFIELD AVE. #6 21206 Items 23a U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel" ~ " any injury or other treumatic even." Black, White, etc. 1 XYes 2 □ No 1 Never Married 2 Married 1954 1 ☐ Yes 2 🗷 No ģ Specify 3 Midowed 4 Divorced **Black** 1961 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION **CARPENTER** 7TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **DUFFIE HUGLEY** HELEN MCELRATH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE WILLIAMS Friend 5004 PLAINFIELD AVE. #6 BALTIMORE, MARYLAND 21206 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation **GARRISON FOREST VETERANS** BALTIMORE, MD 5 Other (Specify) 22. Name and Address of Facility Miller"s Metropolitan Chapel P.C. 110 1639 North Broadway Baltimore, Maryland 21213 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician Cancer Lung months disease or condition resulting in death) /Medical Due to (was a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 No autopsy performed? Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Dther (Specify) 2 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifiei 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) widerich Th 30. Name and address of person and o compared cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

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Amend item#1, perMb 3848, 10/21/05 TT State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last), Ruby Keyser Jackson 2. Dete of Death Month Day Yee Physician 11:10 AM 2005 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Medical NA If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. lest birthday) Days Months Hours Min 1□ M 257 F Director 212-56-8303 57 10-12-48 Va permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Merylend Depertment of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits tem 27 la marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examiner mant be notified at X□ Yes 2□ No Md. Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1014 Comet Street Funerai 21202 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2√2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9th grade Unemployed NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Cook Emma Harris 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricky Jackson Husband 1014 Comet St., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Ponetion 5 □ Other (Specify) ŏ Mt. Carmel Cem. Dundalk, Md. 10-21-05 21. Signature of Funeral Service Licensie 22. Nama and Address of Facility Baltimore, Ma. 21202 March F.H. East 1101 E. North Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Physician /Medical Inmediate Cause (Final Osophage disease or condition resulting in death) Examiner Physician/Medical Examiner ettending physicien end d for use es the bunel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TO RIF JOK PEYMY ed by the e Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by TORACCO ahuse 2 No 3 Probably 4 Unknown 2 of Vital Records, 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy Director; After this certificete hes been in by the funerel director, page 2 should completion of cause of death? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner Other: 20 No 2 1 Yes 12 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Naturel To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director; Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifie 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and eddress of perso 30 81 Pal 32 degistrer's Signature 31. Date filed (Month, Day, Year) State 2 2005 Registrar

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygierre 34108 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) OCTOBER **Physician** 18, LERNER 2005 11:45 MA GERALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Center Saint Joseph Medical Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | OCT 28, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 217-20-2776 77 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itame 23e or 28e-f show the Mudical Executors must be notified at 1 ☐ Yes 2 🔀 No BALTIMORE Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 9010 PITTSFIELD ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. WHITE Specify ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER ABC BOXES permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other traumatic event 9088. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LERNER ANNA **KOLKER** MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9010 PITTSFIELD ROAD - BALTIMORE, MD 21208 CYRIL LERNER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 10/20/2005 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RENAL FAILURE WEEKS /Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an this certificate has autopsy performed? 1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) /18/200 INP D53464 mag 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASON MARX, 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D. . Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DCT 2 1 2005

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** October 14, Wikola Andreyev Mishev /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Manor Care Ruxton Baltimore County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 23,1913 9. Birthplece (State or Foreign Country) Bulgaria 5. Social Security Number 6. Sex 1 3 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 92 046-50-6658 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examinating the confibring Maryland Baltimore County Cockeysville 1 ☐ Yes Ž No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1024 Bosley Road 21030 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 41. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: t Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital 4 n/a Dishwasher other traumatic sysnt, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrei Mishev Vela Nikola To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. (Son) 1024 Bosley Road r.Andrei N. Andreyev Cockeysville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Demetrios Ch.Cem. Oct. 15,2005 Cub Hill, Maryland * 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee re Reace and dourse of Facility tives Funeral Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 Lezur 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Weeks disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours. To the Funeral 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESLER Dr. TONSON MD COMILADI. MD. 1600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAGERSTOWN
If Under 1 Year If Under 24 Hrs. 8. Date
Months Days Hours Min. Mo INDSA WASHINGTON Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□M 2**9**F Q Yrs. 218-24-9373 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Ves 2 □ No Director WASHINGTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code DITER filed within 72 hours after death Hygiene. Funeral α Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>م</u> 3 ₩idowed 4 Divorced NHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1STR 0 or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event 900.8. 18. Mother's Name (First, Middle, Maiden Sumame) Be MER WILLIAM 9 EDITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCN 1058 LINDSAY W HAGERSTOWN ND 31747 MICHAEL MCCORMICK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ANATOMY GIFTS REG 10/5/05 HANCVER, MD * 4 Donation 5 ☐ Other (Specify) 21. Signatur of Further Se 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23a. Part1. Enter the disease or complications that reused the shock, or heart failur. List only also on each line aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition resulting in death) et and Death **Physician** 0 Imo /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in J Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probably 4 Unknown 1X Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate 1 ☐ Yes or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**X** No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 6**X** 3□ DQA 4 Nursing Home 5 Residence 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 12237 Lans suse of death (Item 23a) (Type, Print) 10

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Name (First, Middle, Last) 2. Date of Death **Physician** 0 /Medical 45 City, Town, or Location of Death 4a. Facility Name Examiner 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10h Count 10c. Cita 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code Items 23a Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) rac 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of essie f Health item 27 i mb 21244 other 20a. Method of Disposition 5 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundra Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metrasmana disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9☐ Unknown 9 Unknown þ signed to Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably page 2 should I 2 No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop 2 🗆 No 1 Tes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death Check on one 2 No Other: 1 🗌 Yes esidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 5 3 DOA 4 Nursing Home 28a. Date of Injury (Month, Day Year) 28d. Pesc be how injury occurred Monner of Death 28b. Time of 28c. Injury at Work? After atural 5 Pending ☐ Accident within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and talk of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name a lress of person who completed cause of death (ftem 23a) (Type, Print

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State

Registrar

31. Date filed (Month

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30. Native and address of person who completed cause of death (Item 23a) (Type, Print) July 1- Reed 22511 Jeffersm burn smithshire MD 21783	After this certifice funeral director, Fion: To Be C	2	examiner? 1	dospital: 1 Inp 28a. Date of (Month, 28e. Place of building sician: To the base	Injury Day Year) Injury - At he find the find t	28b. Time of Injury	28c. t M 28c. t M occurred at Ihe estigation, in n	Other: 4 N	Nursing Ho	24a. Was autopperformed to the control of the contr	an 24b. We have an an 24b. We have an an an an an an an an an an an an an	Vere autorior to coneath? Yes '(Specify) or (Specify) or or Rural near as stand due to	No No Route Num	ause o

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			1 - For State Registrar	State of Iviarytand	Certificate of Dea		Reg. No	/1115	34114
		-sales	Decedent's Name (First, Middle, L.)	ast)		2. [Date of Death		3. Time of Death
	Physici /Medic		Darry	Martin			Month Da	y Year 6 2005	2:50 AM
	Examir		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Locat		40	. County of Death	1
	il.	15"		LOFBALTIMOR			TY	NA	
	Funeral Director		5. Social Security Number 6. 217-78-4098	Sex 7. Age (In yrs. last b. 15	Yrs. Months Days Hou	urs Min.	Date of Birth Month, Day, Year, -21-19	63 Han	nplace (State or Foreign untry)
¥.			Usual Residence of Decedent	10		10	~ 1 //!	2) Man	ry land
	arylan show		10a. State 10b. County		vn or Location				10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show rount by notified at	Funeral Director	ud NA	12017	fimore		10- 0:	::	1 Yes 2 No
	with t	D	10e. Street and Number	\mathcal{D}_{a0}	10f. Zip Code 21212		10g. CI	itizen of What Cou	untry?
	death me 23	era	1003 Upnor 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specify	Yes or No-	14. Race - Amer	
و	or Ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 MANo If Yes, Give		xican, Puerto Rica ecify:	n, etc.)	Black, White	o, etc.
21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "natural", or Iteme 23s or 28s-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	•			1210	LUC
15-	within 72 l ene. then "nat	Completed	15. Decedent's (Specify only highest of	grade completed)	 Decedent's Usual Occupation (Give kind of work done during life. DQ NOT use retired) 	most of working	16b. F	Kind of Business/li	ndustry
727	with iiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Cook		K	estauro	ent
MA land	be filed tal Hygid d other event, I	BeC	17. Father's Name (First, Middle, La	st)		other's Name (Fir	st, Middle, Maider	Sumame)	
√ lai		To	Chris Ellidt	+	N	ancy	Ballar	rd	
ץ د Maryl	2 sho	1	19a. Informant's Name/Relationship	(Type, Print) 19	b. Mailing Address (Street and Nu	r or Rural Ro	ute Number, City	_	
	ges 1 and 2 should it of Health and Mer it I Item 27 le marks or other traumatic		20a, Method of Disposition	20b. Place	of Disposition (Mine of	d. De	20c. L	ocation - City or T	バン Town, State
DARR' Baltimore,	Pages nent of int: If It iry or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	1 000000	ery, crematory or other place)	Det 24	200 - B	11 4	0
⊕ altin	그 된 원 중 .		21. Signature of Funer Service Lig		11.00	acility	tunt val	Service	RA
Ö	Dermi Depa Impo eny It		alf m Ci	Thufan	1701 Mc Cull	ok 81.	Balto.	W. 2	1217
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that aused the death. Do ty one cause on each line.	not enter the mode of dying, such	h as cardiac or res	piratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	= Shontaneous	Bacterial Pe	esutori	ta		2 down
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):				1 1-
	le le	-	Sequentially list conditions, if any, leading to immediate	Septicemia Due (or as a consequence	of):				1 day
18	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. End State	live diseo	We .			5 years
ó	be executed sicien end burial-transit		resulting in death) Last	Due to (or as a cons	of):				
8760	<u> </u>	lical		d					
x 68	leath certificate attending phy if for use as the	/Mec	IF FEMALE:	220. If yes, outcome of pregnancy					
Вох	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of deliver Month	very Day Year
0	the di ny the ached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	JE Office (Specify)				
<u>ر</u> . ح	w requires that the deatt been signed by the atte should be detached for	by PI	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in P	Part I.	23e. Did tobacco	use contribute to	the cause of death?
ords	equire en sig ould b						1 ☐ Yes 2	2 □ No 3 □ Pro	bably 4 Unknown
ecc	law ri las be	ompleted					24a. Was an autopsy	prior to co	topsy findings available ompletion of cause of
<u>~</u>	hysicien: The law his certificate has b I director, page 2 s	Con					performed? 1 ☐ Yes 2 🗹 No	death? 1 ☐ Yes	2 No
Vita	certifi	Be	25. Was case referred to medical examiner?	Hospital:	Other	Place of Death (Ch			
to	Phys r this sral di	. To	1 Yes 2 No	28a. Date of Injury 28b.	Time of Injury at Work?	Nursing Home 28d.	5 Residence Describe how inju		ufy)
ion	ttending P death. stor: After	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury Work? M 1 ☐ Yes	2 □No			
Division of Vital Records, P.O	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determine		arm, street, factory, office		Location (Street a. City or Town, State		ral Route Number,
ā	Ital or Irs aft rel Dir led in								
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely tilled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 V Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge arrither: On the basis of examination a and manner stated.	ge, death occurred at the time, dat nd/or investigation, in my opinion,	te and place, and o death occurred a	due to the cause(s t the time, date an	s) and manner as id place, and due	stated. to the cause(s)
	ithin 2	Mec	29b. Signature and title of certifier	and mainer stated.	29c. License numb	ber	29d. Da	ate signed (Month	, Day, Year)
	⊢ <i>≤</i> ⊢ ŏ		▶ \Mgas	MD	RES-C	000	Oct	obea 16	5,2005
	(30. Name and addre s of person wh	no completed cause of death (Item 23a)	(Type, Print)				
					INAI HOSPIT	AL OF	BAL	FIMORE	
45	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	boorle				
95	n.egist		OCT 2 1 201	JJ RECOURSE NO P					

DHMH 17 Rev 1/2001

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Patient Prouin

JC 05-07050 Helen McCoy 1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#17 perFH C848 10-21-05 TT

Amend item#17 of Maryland Department of Health and Mental Hygien 2005 Certificate of Death

-	Decedent's Name (i	First, Middle, Last)
hysician /Medical	Helen	Louise

2 Date of Death

3. Time of Death

Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 216-34-6162 1 M 2 TF 66 Yrs Director Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10h County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Wedical Exarts or must be notified at Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 7274 McClean Blvd 21234 Completed by Funeral deeth permit. Pages 1 and 2 should be filed within 72 hours after deet.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than any injury or other traumment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 Yes XXNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12th grade Administrator 17. Father's Name (First, Middle, Cast) Be John A. Cap Ida Boone 19a. Informant's Name/Relationship (Type, Print) Jesse E. McCoy, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10/22/05 ■ Burial 2 Cremation 3 Removal from State Arbutus Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Icensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 24a. Was an autopsy performed? Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one| examiner? Y Yes 2 □ No 은 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident Injury 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Š 4 | Homicide within 24 hours a To the Funeral (pelli 29a. Certifier Medicai one) 29b. Signature and title of certifier 29c. License number O.C.M.E.

Helen Louise McCov October 0 17, 2005 14:50 P [™] 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner 7274 McClean Blvd. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) July 29,1939Naryland 10d. Inside City Limits Yes 2 No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: USA 16b. Kind of Business/Industry Baltimore City Sanitation Dept. 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4119 Holbrook Road Randallstown, Md 21133 20c. Location - City or Town, State Arbutus, Maryland 22. Name and Address of Facility Chatman-HarrisFuneral Home 5240 Reisterstown Rd Baltimore, Md21215 Approximate Interval Between Onset and Death Hypertensive Atherosclerotic Cardiovascular Discor 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 1 Yes 2 □ No Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) October 18, 2005 tallanna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

2005

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygien 0 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ANN 2005 DCTOBER 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHRIST Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 **Funeral** Days 1 M 2 PF Months 218-34-2303 10 Director NEW JERSEY Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f ehow or other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Funeral Director BALTIMORE IMONIUM 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? #209 21093 DODWORT-INITED 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 You If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER 10 Maryland permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Item 27 is marked oth eny jury or other traumatic event 90cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES E. TRIMBL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LRAIG NEUS I DODWORTH TIMONIUM, MD 21093 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS REGIO/13/05 HANOVER, MD 4 Donation 5 ☐ Other (Specify) 21. Signature | Furnish Service Licensee 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reasi Wear. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o. as a consequence of): Examiner Due to (or as a consequence of) Completed by Physician/Medical be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Month Year 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Scher (Specify) Hospital: Certification: To 1 ☐ Yes 2 反 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA ō funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funaral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TW Certifying Physician: To the best of my knowledge, Jeath occurred at the time, date and place, and due to the cause(s) and manner as slated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 25a, Cortifier Medical (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 125205 Enthon October 13, 2005 uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ralto. ml 6 Bin (M- Charles St. 6701 *6*ау. Г 2 2. Registrar's Signature 31. Date filed (Month, Year) State 1 2005 Registrar

DHMH 17 Rev 1/2001

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		•	1- For State of Maryland / Department	artment of Health and N rtificate of Death	1ental Hygien	4000	34117
F	hysicia	an	1. Decedent's Name (First, Middle, Last) Hasten Newton		2. Date of Death October	ĭ1 2ďő5	3. Time of Death 12:03A M
ı	/Medic Examin		4a. Facility Name (If not institution, give street and number) 12117 Mackell Lane	4b. City, Town, or Location of Death	44	c. County of Death rince Ge	
	uneral rector		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year July 28	9. Birth Coyl 1916 Bah	place (State or Foreign ntry) Iamas
Maryland	f show	ρĮ	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's Bowi				10d. Inside City Limits 1 ☐ Yes 2 No
n with the	3a or 28a at be notifi	ai Direc	10e. Street and Number 15400 Jennings Lane	10f. Zip Code 20721	_	itizen of What Cou SA	ntry?
USO urs after deet	important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 121 Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 【☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B1	etc.
IZID-UUSO within 72 hours af ane.	than "naturals and a Medical 3	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) F. 1	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ectrical Techni	ing	Kind of Business/Inu	
Viana Z Suld be filed a Mental Hygie	rked other tic event, ti	To Be Co	6th 0 17. Father's Name (First, Middle, Last) Richard Newton	18. Mother's Nam	e (First, Middle, Maide ee Roker		
, Mary and 2 shou selth and N	n 27 is ma isr trauma		Melissa Newton(Daughter) 172-0	ng Address <i>(Street and Number or Rur</i> 17 67th Ave Fres	al Route Number, City sh Meadow	or Town, State, Zin	, Code) 11365
Saltimore Sermit. Pages 1.	tant: If Iter jury or oth		4 Donation 5 Other (Specify) Metro C	rematory 10-1	14-05 Ba	Location - City or To	
permit Dapart	any in		Harry J. Flese 8	man rease facilisons 21 West St. Ann	napolis,	y, P.A. Md. 2140	D1 Approximate
/M	physician and edical transit t	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, library leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Demential—End Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):				Inierval Between Onset and Death
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Hecorus, F.O.	been signed by should be deta	þ	Part II. Other significent conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
	certificete hes ber irector, paga 2 sho	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 1 N	prior to co death?	psy findings available mpletion of cause of
DIVISION OF VITA Lor Attending Physician: after deeth.	After this funeral d	ation: To Be	25. Was case referred to medical examiner? 1	nt 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how inju	6 3 S1S 6 3 ther (Special ury occurred	ted Livin
DIVIS		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street a City or Town, Sta	te)	
L To the Hospitel within 24 hours a	To the Funerel Directory completely filled in t	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, exestigation, in my opinion, death occur	red at the time, date ar	nd place, and due to	o the cause(s)
P. Ž	P 8		Max weetsh	D23743		ate signed <i>(Month,</i> -14-05	Day, Ival)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type Martin Weltz 7525 Greenway CTR		, Md. 207	770	
10%	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 1 2005 32) Registrar's Signature	W.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dorothy Henrietta Noll 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale If Under 1 Year If Under 24 Hrs. Franklin Square Hospital Baltimore Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Months Days Hours Min. 213-20-7486 81 Director July 16,1924 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore 1 Yes 2 No Baltimore Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 5117 Hazelwood Avenue 21206 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: Completed by Specify: White 3 XWidowed 4 □ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard LeBrun 2 Henrietta Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 George M. Noll/son 6805 Beech Avenue Baltimore, MD 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith 10/22/05 Rosedale, Maryland 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Fund 1211 Chesaco Avenue Rosedale, MD 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Systemic Inflammatory Response Syndrome **Physician** /Medical Ubue to (or as a consequence of): Examiner Difficile colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed c. Intraperitoneal
Due to (or ds a consequence of): Micro Abscesses that initiated events resulting in death) Last Box 68760, Completed by Physician/Medical Disseminated Candidiasis IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death o. 9□ Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ctoraginal Fistula, Acute Renal Failure 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Trive Depression To 24a. Was an autopsy performed? 217 No 1 ☐ Yes 2 ☐ No 1 Yes ours after death.

Neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠ No 1 Inpatient 2 ER/Outpatient မှ 3 DOA 28a. Da'e of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a
To the Funeral E
completely filled To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of confier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

10

State

OCT 2 1 2005 DHMH 17 Rev 1/2001

Dr.Josephine

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

use of death (Item 23a) (Type, Print)

Owasu-Sakyi, 900 par) P. Registar's Signature

D56381

9000 Franklin Square Drive, Baltimore, MD 21237

			1 - For State Registrar	State of	Marylan		artmen rtificat			ind M	lental Hy	gien Reg. N	711115	34119)
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E	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth av. Year	9. Bir	thplace (State or Forei	gn
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	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limit	ts
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Maryland 21215-0036	s 1 and 2 should f Health and Mer tam 27 is merke other treumetic		19a. Informant's Name/Relations		\								or Town, State, 2	Zip Code)	
	1 and 2 Health tam 27 i		Mary Jane Rob	ison (Daugi		4332			., Wa		rf, MD				_
0	0 0 = 2		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation	3 □Removal from S	tate	emetery, crer	natory or o	ther place	1		ate		ocation - City or	Town, State	
tim			4 □Donation 5 □ Other (S		Pis	sgah Ba						Ri	ce, VA		
Baltimore,	permit. Pag Department Importent: any injury c once.		21. Signature of Funeral Service	2111m	in				s of Facility unera St			. V	A 23901		
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			X \(\lambda \)	My Mi	>			1)5	388	3			10-18.	2005	
	./		30 Name and address of person	who completed cause	of death (Item	23a) (Tvoe	Print)	-	2				, ,	0.00	
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				State of Ma					•	giene Giene	•
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1	Examir	ner	University of Marylane		- 24		1+imore		l	4c. County of De	ath
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1870	Director		218-84-4121 15 Usual Residence of Decedent	_ M 221	32	Yrs.			March2	25,1973 MA	ryland
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	the Ma	ecto	MD Balt:	imore			altimore	3	•	40.00	1 ☐ Yes 2 🔀 No
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ylar	Menta Menta arked aric av	To B	Allen D. Peyto	on Sr.			De	enise	Parri	sh	
Maryland	12 sho h and 7 is m		19a. Informant's Name/Relationship (T) Denise Sawyer/n							er, City or Town, State,	
ē,	is 1 and 2 of Health a Itam 27 is other trace		20a. Method of Disposition	No. of Contract of	20b. Place o	of Disposition (formatory of	Sig Bend		d Batt Date	letown KY 20c. Location - City o	
imo	Page: nent o ant: If ury or		1 ☐ Burial 2 【XCremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State)	Bayv	iewCre	matory	10/	22/05	Baltimor	e MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Bepartment: if Itam 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Maralical Examinat must be natified at ODGs.		21. Signature of Funeral Service Licens	y Con	no Ol		and Address of Fa	Co	onnelly	FuneralH	omeofEssex
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner state	au.						
			Chenel Done	adee MD			16641	وا		10/19/0	15
	2		30. Name and address of person who co		ath (Item 23a)	(Type, Print)	6	<	1 6.	10/19/0	
	Sta	te	Chenell Do 31. Date filed (Month, Day, Year)	32. Resistrar	's Signature	Ana	les mee	ive)	7. 1/4	LTU, MID	
	Registr	ar	OCT 2 1	ZUUD MAR	wind for	Jag Van					

			State of Maryla 1 - Statemend item #11 per Attorney C854	ind / Department of Health and I 4/20/06 am Certificate of Death	Mental Hygiene	2005 34121
\$.	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number)	PEARSALL 4b. City, Town, or Location of Death	2. Date of Death Month, Da OCTOBER 1	3. Time of Death
10000000000000000000000000000000000000	Examin Funeral Director	er	Sinai hospital of Baltimon	rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, DEC: 26, 15	9. Birthplace (State or Foreign Country) 34 NORTH CAROLINA
	r 28e-f ehow	rector	Usual Residence of Decedent 10a. State 10b. County 10c. County MARYLAND N/A 10e. Street and Number	City, Town or Location BALTIMORE 10f. Zip Code	CITY	10d. Inside City Limits 1 1 Yes 2 □ No No itizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-f show other traumatic event, the Marifiel Examinations in will be invitiled at	by Funeral Directo	5250 NELSON ÂVE. 13 11. Marital Status 1	10.S. 13. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Bi Ad V
21215-0036	d within 72 hour giene. er then "natural , the Wadical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work done) iffe. DO NOT use retired) LABORER	rking	CAL UNION
Maryland	2 should be file and Mental Hy is marked othe eumatic event.	To Be (17. Father's Name (First, Middle, Last) EDDIE 19a. Informant's Name/Relationship (Type, Print)	ARSALL LOS	ural Route Number, City	BASS or Town, State, Zip Code)
Baltimore, M	permit. Pages 1 and 2 Department of Health : Importent: If Item 27 i eny injury or other tre		1 M Duriet 2 Commation 2 Pamoual from State	o. Place of Disposition (Name of cemetery, crematory or other place)	26-05 Aug	TO. MD, 21215 .coation - City or Town, State DINGS MILLS, MD. FUNERAL HOME LTIMORE, MD, 21217
\ \ !	Physician /Medical Examiner	10	23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	eath. Do not enter the mode of dying, such as cardial Sequence of): Fection	c or respiratory arrest,	Approximate Interval Between Onset and Death 2 a ays
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Vital Re	sician: The lav certificate has rector, page 2	Be Completed	25. Was case referred to medical examiner? 1 Yes 28 No	Other	autopsy performed? 1 Yes 22N	death? 1 ☐ Yes 2 ☐ No
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funarel Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	28b. Time of Injury at Work? M 1 Yes 2 No	28d. Describe how injute 28f. Location (Street a City or Town, State	ny occurred nd Number or Rural Route Number,
۵	To the Hospital or within 24 hours after To the Funarel Direction completely filled in Inc.	edicai Cer		knowledge, death occurred at the time, date and place nination and/or investigation, in my opinion, death occu		
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DI	regioti	<i>77</i>	COL MIT TOOL	- All All All All All All All All All Al		

DHMH 17 Rev 1/2001

DEARSALL, WILLIAMB

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Provenzano lean 2=10PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dankville VUISING Baltimore omwell If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. (1. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 21√ F 220-22-1330 76 Director 1929 Maruland Usual Residence of Decedent Demit. Pages 1 end 2 should be filed within 72 hours after daath with the Marylend Depertment of Health and Mentel Hygiene. mportant: if Item 27 ie merked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 ie marked other than "natural", or tema 23a or 28a-f ehow other traumetic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Funeral Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Old Harford Rd., Apt. 222 21234 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Angelo Russo Maria Mangione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Lisa Woznicki (daughter) 13726 Manda Mill Lane, Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State □ Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 ☑ Other (Specify) Entombment Parkwood Mausoleum 10/22/05 Parkville. Maryland 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examine The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s tha buriel Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed 1 Tes 2 PNO 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours aftar deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 No Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) P 30. Name and address of person who completed cause of death (Item, 23e) (Type, Print) BIVO Loch 31. Date filed (Month, Day, Year) State OCT 2 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Illiam Scot 005 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) ANNE ARUNDE! SLEN B MARWER HEALTHOF GLENBURNIE RNIE If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 197-40-1002 1**S**M 2□ F Yrs.

10f. Zip Code

1 ☐ Yes 2 ☑ No

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

10c. City, Town or Location

SE CROSSING

Was Decedent Ever Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

10d. Inside City Limits

Approximate Interval Between Onset and Death

10g. Citizen of What Country?

1.5.2

16b. Kind of Business/Industry

23d. Date of delivery

Dav

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No.

2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown

be taken 20; 2000

Year

Month

14. Race - American Indian,

Specify WhITE

Black, White, etc.

1 ☐ Yes 2 No

Physician /Medical Examiner

Usual Residence of Decedent

7866 MANSIDA HO

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

10e. Street and Number

11. Marital Status

10b. County

15. Decedent's Education (Specify only highest grade completed)

10a. State

Funeral Director filed within 72 hours after death with the Maryland

Funeral Director

Completed by

Be

Examiner

ir than "natural", or items 23a or 28a-f show tre Medical Examiner must be notified at if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Item Ma of Health a

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permit. Page Department o Important: if any injury or once.

Maryland 21215-0036

Baltimore,

Pages 1 and 2 should

Physician /Medical Examiner

the death certificate be executed burial-transit and physician is the burial as attending | been signed by the should be detached page 2 has certificate director, this After thi funeral

18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) T. REESE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CROSSING PRATER MD. Z1122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State NIEW CREMATORY 31-05 BALTIMORE 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23å. Part1. Enter the diseas. — complication: Lat caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one of the original line. Immediate Cause (Final disease or condition resulting in death) Cars In any Due to (or as a consequence of): 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. þ 1 🗌 Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 1 HO 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 2 100 Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath 1 Waturat 5 Pending 2 🗌 No 1 🗀 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

o. Records, or Attending hours after death. within 24 hours after death To the Funeral Director: filled in by the

31. Date filed (Month, Day, Year)

30. Name and address of

1 2005

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4000 ■egistrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

man

DHMH 17 Rev 1/2001

State

Registrar

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1 - For State Registrar Reg 2.005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 10:27 PM 2005 OCTOBER ROBERT CLIFFORD PLUMMER 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITY N/A SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days 1 XM 2□ F Hours MARYLAND 44 218-74-0960 Director 9-24-1961 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County in then "netural", or iteme 23a or 28a-f ehow the Mudical Examiner must be notified at 1 Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 2672 W. PARK DR. USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 △Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12)
-12-College (1-4or 5+) LABORER CONSTRUCTION Department of Health and Mental Hyg Important: if item 27 is marked other eny injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DESPERT M. PLUMMER VERA GUY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: if item 27 is VALEETA FOGUS (SISTER) 2672 W. PARK DR. BALTIMORE, MARYLAND 21207 20b. Place of Disposition (Name of Kingen Memorria) 10 Park GARRISON FOREST VET 20c. Location - City or Town, State
Baltimore, MD
05 OWINGS MILLS, 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Oth er (Specify) JONATHAN D, HIBNER Name and Address of Facility REDD FUNERAL SERVICE permit 21. Signature of 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIORGAN STSTEM FAILURE WEEK /Medical Due to (or as a consequence of): Examiner YEMR LIVER FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and the burial-transit YEARS HEPATITIS B C Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ pe 2. No PANCKEATITIS 1 Tes 3 Probably 4 Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: rector, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient Certification: To 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Al investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide Hospital filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number in RES- XXX GCTOBER 16 2005 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUKEY, WMY, MD SINAI MUSELTAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State prode

Amend item#20b-c, per Fn, G848, 10-21-05 TI State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 2005 ctober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 105 stial NA TOPKINS JOHNS If Under 1 Year Mene C If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sax 7. Age (In yrs. last birthday) of Birth th, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 21 F Hours Min Yrs. Director 218-26-5647 9-5 Md. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itams 23e or 28e-f show Its Modical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 Lakewood Ave. Apt. 419 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No þ 3√ Widowed 4 □ Divorced Specify Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) Housekeeping Varies 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If itam 27 is marked o Latraw Jones Elizabeth Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If itam 27 is r or other trai 1401 Lakewood Ave. Apt. 419, Baltimore, Md. 21213 Sandra Armstrong Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Department of Important; If any injury or once. 10-22-05 King Mem. Pk. Randallstown, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter-the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician NTRACRANIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** EBRAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. as the t IF FEMALE: esu. 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 2 autopsy 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 DOA ner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending after death. 1 Yes 2 No 2 Accident investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide Hospitai within 24 hours a To the Funeral L filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) re Williamsent R25-000 OCTOBER 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julic Williams Ma BALTIMORE 6000 NORTH WOLFE STREET MRYLAND Registrar's Signature State 2005 Registrar

			For State Registrer		partment of Health and ertificate of Death	Mental Hygier	7 H H D - 3 k I / h
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Howard E,	Nenng	1	2. Date of Death Month	Oay Year 3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and 7700 Telegraph Road	(number)	4b. City, Town, or Location of Deal Severn		4c. County of Death Anne Arundel
	Funeral	*,	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign
	Director		189-14-7817 ¹ ⅓ ^{M 2□}	F 81 Yrs.	Months Days Hours Min		1924 Pennsylvania
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Maryi -f aho	tor	Maryland Anne Arundel	l Severn			1 ☐ Yes 2X No
	h the	irec	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	23a c	ralD	7700 Telegraph Road		21144		.S.A.
36	be filed within 72 hours after death with the Maryland hat Hyglene. od othar than "natural", or Items 23a or 28a-f ahow avant, I're Madical Exacilinat cust be rediffed at	by Funeral Director	1 Never Married 2 Married 1 Nover Married 2 Married 1 Nover Ma	Decedent Ever in U.S. d Forces? es 2 □ No , Give or Dates:	 Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 X No Specify: 	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade complete	16a. Dec	edent's Usual Occupation	rkina 16b.	Kind of Business/Industry
21	within yene.	Completed	Elementary/Secondary (0-12) Colleg	ge (1-4or 5+)	re kind of work done during most of wo DO NOT use retired)		
	e filed within it Hygiene. othar than '		17. Father's Name (First, Middle, Last)	Tru	ck driver	me (First, Middle, Maid	& P
and	d be f ental } ked ol c ava	To Be		ninger. Sr.		e Davis	or comand,
Maryland	s 1 and 2 should be f Health and Mental itam 27 ia marked other traumatic av	-	19a. Informant's Name/Relationship (Type, Print)		iling Address (Street and Number or R		y or Town, State, Zip Code)
	and 2 salth a n 27 is	1	Howard E. Reninger, III		Melanie Road, Pas		21122
Baltimore,	0 0		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal for	Uni State	position (Name of ematory or other place)		Location - City or Town, State
Ë	t. Pa rtmen rtant: njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune Service Licensee		dge Mem. Park 10/1		
Bai	permi Depa Impo any ii		Walco		22. Name and Address of Facility Gary L. Kaufman Fu	neral Home	at MMP, INC.
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. Do not e	7250 Washington Bl nter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	A126	leimens 0	Treese	Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequence of):			
	Lxaiiiiiei	<u>_</u>	Sequentially list conditions, if any, leading to immediate b.	e to (or as a consequence of):			
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Ó	be executed ician and burial-transit		that initiated events c	e to (or as a consequence of):			
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eco	aw as b 2 sl	ompleted			,	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
I R	Th ate pag	Con				performed	death?
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		Othor	ath (Check only one)	
of	Phys r this eral dii	. To	27. Manner of Death 28a. D	1 ☐ Inpatient 2 ☐ ER/Outpat Pate of Injury 28b. Time	of 28c. Injury at	Home 5 Shesidence 28d. escribe how in	
ion	Attending I r death. actor: After by the funer	atlor	1 Natural 5 Pending (Month, Day Year) Injur	Work? M 1 □ Yes 2 □ No		
Division	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	ertification		lace of Injury - At home, farm, uilding, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Ω	Hospital c	O	29a. Certifier 1 Certifying Physician: To	the best of my knowledge, de	ath occurred at the time, date and plac	and due to the cauce	(c) and manner as clated
	a Hos 24 ho a Fun letely	edical	(Check only 2 Medical Examiner: On t	he basis of examination and/or	investigation, in my opinion, death occ	urred at the time, date a	and place, and due to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of Certifier		29c. License number	29d. [Date signed (Month, Day, Year)
)			1 Um	myns	(1/4/1)	1 00	tola, 14, 2005
	15+1		30. Name and address of person who completed	cause of death Item 23a) (Type 78 Y)	OAG WOOD NO	6CFWBC	RME MUS 21005
	Sta Regist		31. Date filed (Month, Day, Year) 0CT 2 1 2005	2. Segistrar's Signature	pedi		Date signed (Month, Day, Year) TOWN, 14, 2005 RMEMW 2106

			1 - For State Registrar	State of M			artment of H rtificate of L		d Mental H	ygiene	000	34127
	Dhusiai		1. Decedent's Name (First, Middle, La.	st)					2. Date of D			3. Time of Death
	Physici /Medio		Bernice Rei						Oct 17	, 200		10:20 A M
1	Examir	ner_	4a. Facility Name (If not institution, giv				4b. City, Town, or		Death		. County of Death	1
			Ellicott City 5. Social Security Number 6. S	7.00	ndRehab. ge (In yrs. last birt	thelayl	Ellicott	City If Under 24	Hrs. 8. Date of B	$\overline{}$	loward	
	Funeral Director			M 2⊠F 90		Yrs.	Months Days		Min. (Month, L	ay, Year)	Cou	nplace (State or Foreign untry)
			Usual Residence of Decedent						Trep 10	, 19	15 Geoi	rg1a
	anylar ehow	_	10a. State 10b. County		10c. City, Towr	n or Lo	cation					10d. Inside City Limits
	8e-f	Director	Md Howard		Colu	ımB						1 □ Yes 2√ No
	with th		10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	intry?
	ne 23	era	11784 Bright Pas	12. Was Deceden	t Ever in U.S	13 1	2104 Was Decedent of His		2 (Specify Ves or N		SA 14. Race - Amer	ican Indian
"	ours after death with the Marylan ral', or Iteme 23e or 28e-f ehow Examiner must be motified at	Funeral	1 Never Married 2 Married	Armed Forces 1 Yes 2	?	10.	f Yes, specify Cubar	n, Mexican, P	uerto Rican, etc.)		Black, White	
03	72 hours after death with the Maryland natural', or Iteme 23e or 28e-f ehow Iteal Examiner must be motified at	b	3 √Widowed 4 ☐ Divorced	If Yes, Give 1. Year or Dates:			1 ☐ Yes 2 XNo	Specify:			Specify: Whi	Lte
21215-0036	be filed within 72 hours ital Hygiene. Id other then "natural", event, Ihu W. cical Ex.	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a.	(Give	lent's Usual Occupa kind of work done d	uring most of	working	16b. Ki	ind of Business/li	ndustry
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d 2	e filed of Hygie other vent, II	e Co	17. Father's Name (First, Middle, Last)	<u> </u>	#16	91:	stered Nu		Name (First, Middl			
Maryland	should be nd Mental marked o	To B	Thomas Costor	ı					e Elizabe			
ary	2 shou and M is mar	-	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailir	g Address (Street a					
	5 5 5 E		Jim Rei- Son		117	784	Bright Pa	assage	Columbi	a, Mo	1 21044	
ore	es 1 ar of Hea if Item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	cometer	Dispo y, cren	sition (Name of natory or other place)	Date	20c. Lo	ocation - City or T	own, State
Ĕ	Pag ment lent: l		'4 Donation 5 ☐ Other (Specific		Lake C			10,	/21/2005	Mett	cer, Ga	
Baltimore,	permit, Pages 1 Department of H Importent: If Ite eny injury or ot once.		21. Signature of Funeral Service Licer	\$000 \$000	_	555	Name and Address	s of Facility W: nolls F	itzke Fun	eral	Homes,	Inc.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	line.	not ent	er the mode of dying	, such as car	diac or respiratory	arrest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	ATHER	O SULETE	207	10 GAR	dav.	ARCOLAN	2 P	SEASE	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence o	of):		,				
1		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence o	OT):						
V	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events		·	•						
o	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	s a consequence o	of):						ST.
8760,	cate be physici the bu	dicai		d								
9		0	IF FEMALE:	20- 16								
Вох	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy			2	23d. Date of deliv Month	ery Day Year
0	0 0 0	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	at time of death	5 [Other (specify)					
S, P.	£ 2 € 8	by Ph	Part II. Other significant conditions of	ontributing to death	but not resulting in	the ur	nderlying cause give	n in Part I.	23e. Did	tobacco u	se contribute to t	the cause of death?
rds	quires an signe uld be		DEMENTIA						1	Yes 2[□No 3□Prol	bably 4 Unknown
Vital Record	aw requir is been si 2 should	ompieted							24a. Was		24b. Were auto	opsy findings available
B.	The law i ate has be page 2 sh	Com							— auto perf 1 ☐ Yes	ormed2	death?	ompletion of cause of
/ita	yeicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					26. Place of	Death (Check only			
of \	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		`	The state of the s	4 L Mursin	ng Home 5 ☐ Res			fy)
Ξ	ing After une	ertification;	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		ime of ijury	28c. Injury Work	?	28d. Describe	how injury	y occurred	
Division	Attending r death, ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be		jury - At home, far	m str		es 2 □ No	28f Location	(Street and	d Number or Rura	al Pouta Number
Ω		erti	4 Homicide determined	building, e	tc. (Specify)	III, Jule	set, factory, office			wn, State)		a Houle Wantber,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examination and	, death	occurred at the time estigation, in my opi	e, date and pl nion, death o	ace, and due to the	cause(s) date and	and manner as s	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier				29c. License	number	1	29d. Date	e signed (Month,	Day, Year)
)			Franklink ?	1			10000	ROSEL	0	Mari	RAD I	7 2001
	/		30. Name and address of person who	ompleted cause of	death (Item 23a) (Type, I	Print)	00		~ / "	34-	1, 00-1
	2			TERPAL	201 1	5A	CK RAW	er 1	ECK, B	ALT	more	·, ms
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 2	005 32. Fegist	rar's Signature	Sp	1960 (Print)					

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month SAMUE OCTOBER 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN DARLI If Under 1 Year ear if Under 24 Hrs. HARFURD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Days Min. 220-22-564 Yrs. Director 126 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 la markad other than "natural", or Itema 23a or 28a-f ehow other traumatic avant, the Mudical Examiner must be notified at 1 Pres 2 □ No Director HARFORD INGTO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral add 1 INITED 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If itam 27 Is marked other than "natural", or Ite 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced NHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGINA RIGNEY DARUNGTON ND 3 1034

20c. Location - City or Town, State 2227 GUEN COVERD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ANATOMY GIFTS REGIO/17/05 HANOVER, MD * 4 Stronation 5 ☐ Other (Specify) 21. Signatur Jun Servic License 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Enysician ancreatic Metastatic 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2□ No 1 🔲 Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check of one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

MIN (N.D.) COR South Atwood Road # 200, Bel Air MD21014 32 Registrar's Signature 2005 Registra

Robert Redd 05-06913 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	PD		1 - For Stete Registrer	State of Maryla	nd / Depa		t of H	ealth a		ental Hy		-	34129
	Physici /Medic		1. Decedent's Name (First, Middle, Las Robert L. Redo							2. Date of De Month October	Da	y Year 2005	3. Time of Death
	Examin Funeral		4a. Facility Name (If not institution, given Howard County Gen 5. Social Security Number 6. S	eral Hospital	s. last birthday) 47 Yrs.	Colu	mbia	If Under 2	Death	8. Date of Bir	4c H	County of Dealoward	tholace (State or Foreign
	Director		219-70-3155 Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo				N	IOV 19	9 19	957 Mai	ovintn) Cyland 10d. Inside City Limits
	r 28a-f at	rector	Maryland Anne A 10e. Street and Number	rundel	Annapo	lis 10f.Zip	Code				10g. Ci	tizen of What C	1 X Yes 2 □ No ountry?
	death with	by Funeral Director	1965 Forest Dr	12. Was Decedent Ever in	U.S. 13.		1401		in? (Spec	ify Yes or No ican, etc.)		USA 14. Race - Am	
9000	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f ahow Le Medical Exe. blow mast be notified at	d by Fur	XXVever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 🗆 Yes	% □ No	Specify:	, Puerto R	ican, etc.)		Black, Whi	
21215-0036	i within 72 h jiene. r then "netu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th	ducation (de completed) College (1-4or 5+)	life.	dent's Usua kind of wo DO NOT u	rk done di se retired)	uring most	of working	9		ind of Business	
Maryland 2	ould be filed v Mental Hygie verked other t	To Be C	17. Father's Name (First, Middle, Last) Robert L. Redd	Sr.				Virg	jinia	First, Middle, a Peti	Maider tig:	Sumame)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ahow eny injury or other traumatic event, Ite Medical Exaction master master rediffered at once.		19a. Informant's Name/Relationship (Michelle Clark 20a. Method of Disposition → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	(Cousin)		W. I	Earl	eigh	Hei	ghts	Rd.	Sever ocation - City or	na Pk. Md Town, State
Baltir	permit. P Departme Importen eny injur.		21. Signature of Funeral Service Licer	1590	W	Mame ar M • R	nd Address eese est	s of Facility	ons	Morti	ıarı	y, P.A Md. 21	
8760,	Physician Medical Examiner Physician and physician and physician and physician are physician and physician are physician and physician are	Icai Examiner	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	oul mon equence of):						rrest,		Approximate Interval Between Onset and Death
.O. Box 6	Attanding Physicien: The law requires that the death certifics death. r death. ector: Atter this certificate hes been signed by the attending pt by the funeral director, page 2 should be detached for use as to the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3[Ectopic pr						23d. Date of de Month	livery Day Year
٥.	w requires that been signed b should be deta	þ	Part II. Other significant conditions o	ontributing to death but not re	sulting in the u	nderlying c	ause give	n in Part I.			obacco i		o the cause of death?
al Reco	ticien: The law r certificete hes be rector, page 2 sh	Completed								24a. Was autop perio 1 Des	rmed?	prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	nding Physicien: ath. r: After this certific e funeral director.	ation; To Be	25. Was case referred to medical examiner? XXYes 2 \(\) No 27. Manner of Death 1 \(\) \(\) \(\) \(\) Natural 5 \(\) Pending 2 \(\) Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		8c. Injury Work	r: 4 🗆 Nurs	sing Home	Check only o	dence	6 Other (Spe	icify)
Divis	Dirte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str ify)	eet, factory	y, office		28	of, Location (S City or Tow			ural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	ysicien: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, death ation and/or in	occurred vestigation	at the time , in my opi	e, date and inion, death	l place, an n occurred	d due to the d I at the time, i	cause(s date and) and manner as d place, and due	s stated. a to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier Jasha?	Acces ON	10	13	. C.M.			- 1		te signed (Mont	
			30. Name and address of person who Tasha Z Gree		om 23a) (Type, .11 Penr	Print)			more			ber 11, 1 21201	, 2003
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 1 20	32 Segistrar's Sign	nature					,			

DHMH 17 Rev 1/2001

ORIGINAL

Patient knows as Hula Robinson Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
	For	State of Maryland / Department of Health and Mental Hygiene Certificate of Death
1-	For Stata Ragistrar	Certificate of Death Reg. No. UU J

	•	For Stata Ragistrar		State of W	aiylaii		rtificate of L		мена пу	Reg. No	uua	34130
Physicia	an	1. Decedent's Name		st)					2. Date of De Month	Da	y Year	3. Time of Death
/Medic		Hula M.]		e street and number)		4b. City, Town, or	Location of Deat	Octob		2005 County of Dea	
Examin	er		tospita		time	ne	Baltin	ore C	ites	40.	County of Dea	uı
Funeral Director		5. Social Security N 143–20–8611	lumber 6. S	`	ge (In yrs.	la <i>st birthd</i> ay Yrs.	Months Days	If Under 24 Hrs Hours Min		av. Year)	C	thplace (State or Foreign ountry) th Carolina
land		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
Mary	to	MD	NA			Balt:	imore					1 X Yes 2 □ No
th the	Jirec	10e. Street and Nur	mber		-1		10f. Zip Code			10g. Cit	izen of What Co	ountry?
ath w	rai		eville Aven					21207			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	by Funeral Director	11. Marital Status 1 □ Nøver Marri 3 【 Widowed	ed 2 Married 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 1	?	S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
72 hou	ted	/Co.co	15. Decedent's Ed			16a. Dece	dent's Usual Occupa	tion	-1-1-	16b. K	ind of Business	
ithin 7	Completed	Elementary/Seco	ndary (0-12)	College (1-4or	5+)	life.	kind of work done d DO NOT use retired	uring most of wo	nking		D	• _
iled w Hygier ther th		10 17. Father's Name ((First Middle ast				Housewife	10 Mother's No.	= Cinot Middle	A do into a	Domest:	ıc
d be f antal h ced ol	o Be	Edward She						Ella Si	me (First, Middle teed	, Maiden	Sumame)	
shoul nd Me mark	2	19a. Informant's Na		Type, Print)		19b. Mail	ing Address (Street a			er, City o	r Town, State,	Zip Code)
and 2 alth a alth a 27 le		Clarence	Shearin/S	on			Belleville A					
of He of He if Item or oth		20a. Method of Disp		Removal from State	20b. P	lace of Disp emetery, cre	osition (Name of matory or other place)	Date	20c. Lo	cation - City or	Town, State
Pag ment tent: I			5 Other (Specify		'		emetery	10-25	5-06	Lans	downe, M)
permit Depart Import any in once.		21. Signature of Fu	neral Service Licer	pnes			2. Name and Addres ylie Funeral		. 638 N.G	ilmor	St. Bal	to, MD21217
Physician /Medical Examiner		23a. Part1. Enter the shock, or head immediate Cause (disease or condition resulting in death)	rt failure. List only Final	plications that cause one cause on each I a. Due to (or as	ine. Seps	3/5	ter the mode of dying	, such as cardia	c or røspiratory a	rrest,		Approximate Interval Between Onset and Death 3 days
	ai Examiner											
physicate sthe l	Medicai			d								
m .≒ m	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal	death 3[□Ectopic pregnancy □ Other (specify)			2	23d. Date of del Month	ivery Day Y <i>e</i> ar
s that med to e deta	by P	Part II. Other signifi	icant conditions c	ontributing to death t	out not resu	alting in the u	inderlying cause give	n in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
equire en siç ould b	ted t	Ischemi	c encept	ralopatly	y, t	typer	tension,		1 🗆 '	Y <i>e</i> s 2[□No 3□Pr	obably 4 dnknown
The law rate has be page 2 sh	Completed	Chronic	renal 1	nalopatlu insufficie	ncy						24b. Were au prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of
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Physic this cral dir	. To	1 ☐ Yes 2 ☑ 27. Manner of Death		1 ☑ Inpati		ER/Outpatie	nt 3□ DOA Othe f 28c. Injury	4 Nursing H	lome 5 Resident	dence 6	Other (Spec	cify)
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	(Month, Da	iy Year) jury - At ho	Injury mø, farm, st	Wark'	es 2 No		Street and	d Number or Ru	iral Route Number,
e Hospitel c 24 hours af 8 Funerel D etely filled ir	Medical Cer	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exen	ysician: To the best	of my know	wledge, deat	h occurred at the time	e, date and place nion, death occu	and due to the	cause(s)	and manner as	stated. to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 October 17, 2005										
2		30. Name and addre	ess of person who	completed cause of o	death (Item	23a) (Туре, ИЙ I	D: 0					,
Sta Registra		31. Date filed (Mont	th, Day, Year) 2 1 2005	32. Registr	ar's Signat	Soore Proces	Hospital		<u>-</u>			

			for State Registrar	State of Maryland		nt of Health and lete of Death		eng 005	34131
	Physici	an	Decedent's Name (First, Middle, Last)	Vall Sr			2. Date of Death		3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give si Maryand Gen 5. Social Security Number 6. Sex	PRUL HUSPI 7. Age (In yis. ias	tal Fai	Town, or Location of Death	8. Date of Birth	4c. County of Death	h hplace (State or Foreign
d.	Director		Usual Residence of Decedent	M 2□ F 6	Yrs.	Bayo Hodio IIII	Aug. 19,	1944 NOF	Hi Carolina
	Maryian I-f ehow	tor	Maryland Harfor	-d 10c. City,	dae WD	od			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	I Director	10e. Street and Number	Saure N) 101. Z	D Code	10	g. Citizen of What Co	untry?
36	rs after death I', or Iteme 2:	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decilif Yes, sp	edent of Hispanic Origin? (Secrity Cuban, Mexican, Puer 2 No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28a-f show other traumatic event, the Madical Examination is maillist.	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	rking 1	6b. Kind of Business/	Industry
	be filed tal Hygie d other event, Il	Be	17. Father's Name (First, Middle, Last)	1.11 C	Ship	18. Mother's Nai	me (First, Middle, M	aiden Sumame)	
Maryland	2 should be and Mental le marked reumatic ev	ပို	19a. Informant's Name/Relationship (Type	VAII DE.	19b. Mailing Addres	s (Street and Number or Ri	ural Route Number,	City or Town, State, Z	Sip Code) 21949
Baltimore, N	9 0 = =		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	Cer	ce of Disposition (Nonetery, crematory or	ame of other place)	Date 2 29/2005	Oc. Location - City or	#wn, State
Baltin	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service/License	(Buss	Josep	h L. Russ	Funeral Balto	Home P. Vid. 21216	A.
- 6	Physician		23a. Part / Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	eations that caused the death.	Do not enter the mo	de of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Polymer Polymer					1/2/2016
8760,	death certificate be executed e attending physicien and dor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	Immun	odeficience	j Syna	drome	I week
Box 6	ne death certific the attending p thed for use as i	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3 Ectopic		10	23d. Date of dela Month	ivery Day Year
rds, P.O.	The law requires thet the de ate hes been signed by the a bage 2 should be detached I	þ	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying	cause given in Part I.		acco use contribute to	
of Vital Records,		Completed						ed? prior to death?	utopsy findings available completion of cause of
Ž.	Physician: 1 this certificat ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 □ E	R/Outpatient 3 [Other	ath (Check only one Home 5 ☐ Resider	nce 6 ⊡Other <i>(Spe</i> o	cify)
o uo	ing Phy After thi		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
Division	el or Attending Ples after death. I Director: After the in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number.
	Hospit 4 hour Funera ely fille	edical (ician: To the best of my know er: On the basis of examination and manner statad.					
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	Ds De Goverde	2	9c. License number \$9569		d. Date signed (Month	
	4		30. Name and address of person who co	mpleted cause of death (Item 2	.0.40	89569 Marylane	l Gener	eal Hosp	rital
	Sta Regist		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) 0CT 2 1 200	32 Registrar's Signatu	Jin Contraction				
DH	IMH 17 Rev 1/2	001	W 1 W 1 EUU	Jakan Ja	1				

ORIGINAL

			1 - For State Registrar	State of Marylan		tment of H			ene 2.005	34132
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	eth	Swi	1 geri		2. Date of Death Month October	Day Year	3. Time of Death
j.	Examir		, , ,	ndStream	DR.	Col	Location of Death		4c. County of Dear	VATD Co.
	Funeral Director		5. Social Security Number 189-28-3275 Usual Residence of Decedent	7. Age (In yrs.)		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 23	1939 PC	hplace (State or Foreign buntry) ANSY VANIO
	Maryland I-f show	tor	10a. State 10b. County Howa		, Town or Loca	tion	nbia			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23s or 28s-f show finust be notified at	Funeral Director	10e. Street and Number 10073-5 Wind	dstream D	R,	10f. Zip Code	1044	10	g. Citizen of What Co	untry?
920	after or Its	b		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ØNo If Yes, Give Year or Dates:		s Decedent of Hi es, specify Cuba Yes 200 No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within 72 ho iene. 'than "natur ine M. olical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give kit	nt's Usual Occupand of work done of NOT use retired	during most of working)	ler 1	6b. Kind of Business, Self Emp	Industry COYED
aryland?	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last)	4224			18. Mother's Name			
Σ	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Brenda Swyger	T- WIFE	10073	5 W	ind Stream	m DR. (md, 21044
Baltimore	permit. Pages 1 Department of H mportent: If Ite Iny injury or otl		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ R 4 □ Donation 5 Ø Other (Specify) 21. Signature of Fureral Service Users	enloval from state Cold	embia	ion (Name of tory or other place Mem , Po lame and Addres	s of Facility	105 6	Oc. Location - City or Olumbia Poss	Town, State Maryland
8	10284		23a. Part 1. Exter the disease, or complishock, or bear failure. List only or Immediate Cause (Final	cations that caused the death	Ga	ry P.m	arest Fun	eral Home	, Bayoin	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or asy consequence)	sence of):	iá	ioan c	ances		
760, <	te be executed ysicien and ie burial-transit	cal Examiner	Sequentiary is conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to or as a conseq	10 phe	agea				
P.O. Box 68	that the death certificate be executed ed by the attending physicien and detached for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3□E	ctopic pregnancy other (specify)			23d. Date of deli	very Day Year
	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions cor			ertying cause give			cco use contribute to	the cause of death?
Vital Records,		Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Vita	ysicien: The is certificate director, pag	To Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatient	3 DOA Othe	26. Place of Death		ce 6 Other (Spec	200
ion of	ting Ph J. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how		any)
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	·)			City or Town,		
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the formulation of th	edical	29a. Certifier (Check only one) Check only one) Continue Contin	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death o ion and/or inves	ccurred at the time stigation, in my op	e, date and place, a pinion, death occurre	nd due to the cau ad at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
)	To the To the comp	W	29b. Signature and title of certifier	M.		29c. License	870	290 O	d. Date signed (Month	7) 2005 (NJ) 2009
-	6		30. Name and address of person who co	5005 8	Bung	" Bell	lane	Claes	houller	ND 21029
DH	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) — GCT 2 1 2005	32. Registrar's Signal						
,					ORIGINAL					

Lenneth Suygeet

		Chate of Mandand / Denote the Hit		
		1- State of Maryland / Department of Health and Certificate of Death	Mental Hygie	2005 34133
			Reg	
Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3, Time of Death
/Medic	al	MAUDE E. DCHIEY	OCT	17 2005 d:05 M
Examine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Death
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	5 0 D-1(Di-t	MARTORIS
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month Day V	9. Birthplace (State or Foreign
		Usual Residence of Decedent	7/28/1	974 MARYLAND
/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Man Man	ţō	MD BALTIMORE BALTIMORE		1 ☐ Yes 2 ☐ N 0
death with the Maryland ms 23a or 28a-f show rinust be notified at	Funeral Director	10e. Street and Numbers 10f. Zip Code	10g	. Citizen of What Country?
h with	<u></u>	2810 KINGS KIDGE KD 21234		USA
deatl	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - American Indian,
after or Ite	Ē	1 Never Married 2 Married 1 Yes 2 No	to Hican, etc.)	Black, White, etc.
ours all.	i by	3 Wildowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify:		Specify: WHITE
5-0 72 h 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	ndking 161	b. Kind of Business/Industry
fifthin fifthin	npt	Elementary/Secondary (0-12) College (1-4or 5+)		2
oed w	S	12 HOMEMAKER		KESIDENCE
Ind be fill d oth	Be		me (First, Middle, Mai	iden Surname)
Van Van Van Van Van Van Van Van Van Van	ပ္		RIE W	ACTEEN
Maryland 21215-0036 to 2 should be filed within 72 hours aff th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Evani		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	1/	11
		JOYCE JURNER - NIECE 6943 MT. VISTA KD	MINES	
Orch File		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of D	Date 200	Location - City or Town, State
Familiment: Parising Jury		"4 Donation 5 Other (Specify) FALKUCOS (EMETERY 20,	2005	ARKVILLE MD
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or otha		21. Signature of F feral Service Licensee 22. Name and Address of Facility	LANS FUN	ERAC CHAPEC
205.00	_	167-90 Sel 8800 HARFOR	O RD.	PARKUILLE, MD 21234
		23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):		7.3.135%
1000		Sequentially list conditions, b.		
/ P = 30	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
and -tran	кап	Cause (usease or injury that initiated events c		
		oue to (or as a consequence of).		
687 tiflicate g physias the	dlcal	d		
Se as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		T
Bo Baath auten for u	lan	in the past 12 months?		23d. Date of delivery Month Day Year
O et et bed	yslo	1 ☐ Yes 2 ☑ No 4 ☐ Fregnant at time of death 5 ☐ Other (specify)		
P. P. that that dela dela		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ds, ds, ds, ds, ds, ds, ds, ds, ds, ds,	d by	CRI, CHF, LIO CAD	1 ☐ Yes	
Vital Record Vital Record Iclan: The law requir certificate has been si rector, page 2 should	Completed		74- 146	
Rec in has ge 2	mp		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Z = = :: # :: # :: page:			1 ☐ Yes 2 ☑	
Sector Sector	Be		ath (Check only one)	
Phys Phys	. To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing H	dome 5 Residence 28d. Describe how i	e 6 ☐Other (Specify)
After fune	tou	1. Natural 5 Pending (Month, Day Year) Injury Work?	200. Describe now i	nary occurred
Division or Attending after death. Diractor: After i in by the fune	fica	3 Suicide 6 Could not be	28f Location (Stree	t and Number or Rural Route Number,
Div affer Div	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, S	tate)
		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	a, and due to the cause	e(s) and manner as stated.
e Ho 124 P na Fu iletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	irred at the time, date	and place, and due to the cause(s)
To th withir ro th comp	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
		D26202		10/17/05
	Ī	30. Name an addre person who completed cause of death (Item 23a) (Type, Print)		
Q		30. Name an addres reperson who completed cause of death (Item 23a) (Type, Print) SHILPI KHOSHY 206 HAXI IT #102, BELAIR MD	21014.	
Stat	te	21 Date filed (Month Day Year) 22 Projetrarie Signature		
Registra	ar	OCT 2 1 2005 Leve & Sparke		

			For State of Mary	land / Department of Health and M Certificate of Death	lental Hygien 2005	34134
	Physici	an.	Decedent's Name (First, Middle, Last)		Reg. No. 2. Date of Death Month Day Yea	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and margher)	4b. City, Town, or Location of Death	10 17 2005	N S M
	Examin	er	4363 Com Dinger KD	DARLINGTON	4c. County of De	-
	Funeral Director	,	212-20:4972 10M 28F 8	n yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. B	irthplace (State or Foreign Country)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10	Dc. City, Town or Location		10d. Inside City Limits
	e Man 3e-f sh	Director	MD HARFORD	DARLINGTON		1 □Yes 2 ☑No
	with the or 21		10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	Country?
	death	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		nerican Indian,
21215-0036	be filed within 72 hours after death with the Maryland its Hygiene. And Hygiene death Hygiene defect the world the Theorem 1 the Medical Exercitive most be notified at event, the Medical Exercitive most be notified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Rican, etc.) Black, Wh Specify:	SHITE
15-0	n 72 h "natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Busines	s/Industry
212	filed within Hygiene. ther than " int, I'm Me.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	HOME MAKER	OWN	HOME
and	t be filed ntal Hygided ed other event, I	Be	17. Father's Name (First, Middle, Last) CHARLES FRAN		(First, Middle, Maiden Sumame)	Mill
Maryland	2 should be and Mental is marked o aumatic eve	일	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, City or Town, State	, Zip Code)
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		JOHN SCHUNTER JR, JON	3541 ADY KD	STREET, M	D 21154
Baltimore,	0 0		1 Burial 2 Cremation 3 Removal from State	cemetery, crematory or other place)	Date 20c. Location - City of	Line Com, State
altir	permit. Pag Department Important: I any injury o		21. Sign that A Funeral Series Licensee	22. Name and Address of Facility EVA	DOS TOKESI NS FINERAL CHA	PEL-BEL AIR
B B	8958		VIOI22		R. FEREST HILL	MD 21050
	Dhusisian		23a. Part1. Enter the disease complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	-		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a co	ESTIVE HEART FAI	LUKE	OVER I YEAR
Ų.	Examiner	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	SCLEROTIC CARDIO VASC	CULAR DISEASE W	CIET 548
1	outed id ansit	Examine	nauco Enter I Inderlying	IMER'S DISEASE W	ITH DEMENTIA	OVER 548
8760,	cate be executed physician and the burial-transit		Due to (or as a co	onsequence of):	ENSE	OVER SYR
687		edical	d. CONOR	THIS	E/JSE	-725
Вох	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of past 1 □ Live birth 2 □		23d. Date of d	
0.	at the dea by the at tached fo	yslcl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	e of death 5 Other (specify)	Month	Day Year
0	es that ligned by	by Ph	Part II. Other significant conditions contributing to death but n	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
Records,	w require been sig should b				1 ☐ Yes 2 ☐ No 3 ☐ F	Probably 4 Munknown
Rec	The law ate has b page 2 sl	Completed			autopsy prior to performed? death?	autopsy findings available completion of cause of
Vital		Be Co	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☑ No 1 ☐ Ye 1 (Check only one)	s 2 No
of V	Phys this al dii	မ	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury		me 5 Residence 6 Thother (Sp	ecity) LIVING
lon	ding After fune	atlon	1 Natural 5 ☐ Pending (Month, Day Ye	28b. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (\$\(\)	- At home, farm, street, factory, office Specify)	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Direct completely filled in the formulate of the form		29a. Certifier 12 Certifying Physician: To the best of m	ny knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner a	as stated.
	To the Ho within 24 I To the Fu completely	Medical	one) 2 Medical Exeminer: On the basis of examiner stated	amination and/or investigation, in my opinion, death occurre	ed at the time, date and place, and du	ie to the cause(s)
	with To	~	29b. Signature and title of gertifier	29c. License number D0016389	29d. Date signed (Mor	
	d		30. Name and address of person who completed cause of death	Millem 23a) (Type, Print) M:D, 1716 HALFORD RY	2 - COUNT	, 2003
	0				Su. 106 PALLS	12NMD 21047
	Sta Registr		OCT 2 1 2005	Signature Aparlle		

State of Maryland / Department of Health and Mental Hygienes 34135 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 18, 2005 **Physician** William Stroh 9:45am м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6503 Sacramento Drive Carrol1 Svkesville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 29 1943 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∭ M 2□ F 217-40-9554 61 Yrs. Director Md Usual Residence of Decedent 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at Md Carrol1 Sykesville Director 1 ☐ Yes 2 ☑ No the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6503 Sacramento Drive 21784 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ⁴ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be tiled within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) senior engineer OPS Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Peges 1 and 2 should be Depertment of Health and Menta Important: If Item 27 is marked eny injury or other traumatic events. William Henry Stroh Sr. Annie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheri Stroh (spouse) 6503 Sacramento Dr., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lake View Memorial 10-21-05 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Fa HAIGHT FUNERA Sykesville, M Duan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). certificate be executed ettending physicien and for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the caust of death? Records, þ 1 Tes 2 🗆 No 3 Probably Unknown should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificete 1 ☐ Yes 2 ☐ No 1 Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Cleck only one Hospital: Other: 4 Nursing Home 1 🗌 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death

1. Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Septifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) euter Street Date filed (Month Day, Year) 31 32. Registrar's Signature State 2005 Registrar

			an State	State of Marylan	d / Departme	ent of Health and I			34136
* **		2.45	Registrar Decedent's Name (First, Middle, Last)		Certifica	ile UI DealiT	2. Date of Death		3. Time of Death
	hysicia /Medic		Byron Scot	+				Day Year	5 755 A.M
	xamin	100	4a. Facility Name (If not institution, give st	Medical C	enter B	ty, Town, or Location of Death		4c. County of Deat	th
	neral ector		5. Social Security Number 6. Sex 1553-45-5584	M 2□F	Q Yrs. If Und Month	der 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth Onth Day, Ge	9. Birt	thplace (State or Foreign buntry)
yland	MOI III		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location	.1			10d. Inside City Limits
be filed within 72 hours after death with the Maryland Ital Hygiene.	ilom 27 ie marked other then "naturel", or lems 23e or 28e-f show other treumstic event, the Medical Exeminar must be multified at	Director	MD Baltin	rore Ou	M Spylc	Zio Code	100 (Citizen of What Co	1 Yes 2 No
th with	Nems 238 or		7327 Leigh Cho	ice Ct.		21117	109.	USA	, and y
er dea	Nei Di	Funerai		Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	cedent of Hispanic Origin? (S becify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
urs aft	naturel, or	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: B	ack
72 ho	natur	eted	15. Decedent's Educi (Specify only highest grade	ation completed)	16a. Decedent's U	work done during most of wor	rking 16b.	Kind of Business/	/Industry
withir jiene.	r then the Mis	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	State	(rooper	S	ate of	Maryland
be filed yell Hyg	d othe	Be	17 Jather's Name (First, Middle, Last)	1,1	1111		ne (First, Middle, Maid	an Sumame)	9/13.63[
thould by Men	marked other matic event, I	2	19a. Informant's Name/Relationship (Typ	e Phint)	19h Mailing Addre	ess (Street and Number or Ru	e Ree	C Tollun Store	Zin Code)
	er treu		Denise L. Scott	·/Wite	G277 1	igh Choice (t. Howng	is Mills,	MD 21117
Pages 1 and the nent of He	importent: if item 27 eny injury or other tr <u>pnce.</u>		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re		Place of Disposition (Accemetery, crematory of	lade of cerner place)	Date 200.	Location - City or	Town, State
permit. Pages Depertment of	ortent injury		4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenser		arrison t	and Applies of Factor	27105 Or	angs M	1718, 1410
permit. Depertr	eny ir		Naughn C. Yr	eene	8728	Liberty Rd.	Randalls-	town, M	
	- AS		23a. Part1. Enterthe disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not enter the m	ode of dying, such as cardiad	or respiratory arrest,	•	Approximate Interval Between Onset and Death
	ician dical		Immediate Cause (Final disease or condition resulting in death)	Metastat		tocellular	Carcina	na	5 months
Exar	niner		Sequentially list conditions, b.		100.100 01).				
pet	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence of):				
• вхесп	an and rial-tra		that initiated events c. resulting in death) Last	Due to (or as a conseq	juence of):				
cate be	physicien and the burial-transit	dicai	d.						
certific	nding p	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna				23d. Date of deli	iverv
UNISION OF VICE INCOMINGS, IT.O. DOX OF OU., To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.	been signed by the ettending t should be detached for use as	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown				Month	Day Year
that th	detac	y Physi	Part II. Other significant conditions cont	nbuting to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
	en sign	ted by					1 🗆 Yes	2 □ No 3 □ Pro	obably jUnknown
e lawr	has be je 2 sh	ompieted					24a. Was an aulopsy	24b. Were au	itopsy findings available completion of cause of
י די	ificete or, pag	e Co	25. Was case referred to medical			26 Blace of Dec	performed? 1 Yes 2 A		2 No
ysicie	direct	To B		ospital: 1 Inpatient 2	ER/Outpatient 3	04	lome 5 Residence	6 □Other (Spec	cify)
nding Pl	After th funeral		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
Attend	oy the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	ome, farm, street, fact	1 Yes 2 No	28f. Location (Street	and Number or Ru	ural Route Number,
itel or	ral Dir	0	4 Homicide	building, etc. (Specif			City or Town, Sta		
Hosp 24 hou	To the Funeral Director: After this certificete has scompletely filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying Physic (Check only one) Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
To the within	To th compl	Me	29b. Signature and title of certifier		2	29c. License number May	yland 29d. C	ate signed (Monti	h, Day, Year)
0	1		1 Yang a N		mo	D 31586	0	CT 20	2005
10	-		30. Name and address of person who cor	npleted cause of death (Item	n 23a) (Type, Print) M.D. Z	D31586 25 South Gre	eene St. P	Baltimo.	re, MD
	Sta Registr		31. Date filed (Monuel, Day, Year)	32. Rightstrar's Signa	ature foral				

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Wyer1 Lawson Smith Name Mary Alice Lenhart	036	urs after des ai', or Items Examiner m	þ	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 X If Yes, Give	s?] No					Specify Yes or No to Rican, etc.))-	Black, Whi	te, etc.
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23a. Part. Enter the disease. or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Part Chief the disease. Or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Pinal Program and Dyan Approximate indiring the death.) Due to (or as a consequence of):	rylan	be d	To Be	Myerl Law	son Sm		Ob Mailie	- Address		Mary	Alice		Lenha	
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Due to (or as a consequence of): d. Due to (or as a consequence of): Due to (or as a co		Examiner	ē	Sequentially list conditions, if any, leading to immediate		s a consequenc	e of):							
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Subject shot self 25. Was case referred to medical evaniner? 11	9		/Med		220 If you outcom	o of								
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Second S	o. O.	s that gned b		Part II. Dther significant conditions	contributing to death	but not resulting	g in the u	nderlying ca	use given i	n Part I.	23e. Did t	obacco	use contribute to	the cause of death?
Second S	ord	equire en sig	ted	Esopha	yeal (anc	er				1/0`	Yes 2	XNo 3□P	robably 4 Dunknown
26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending investigation investigation and/or investigation. In my opinion, death occurred at the time, date and place, and due to the cause(s) 28. Date of Injury At home, farm, street, factory, office and number of the building, etc. (Specify) 29. Certifier 299. Signature and title of certifier 299. Signature and difference of peath (Check only one) 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending investigation investigation investigation investigation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 27. Manner of Death 1 Natural 5 Pending investigation investigation investigation investigation investigation investigation. 28a. Date of Injury 2 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28c. Injury at Work? 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or		9 4 9	comple		/						autor	rmed?	prior to death?	completion of cause of
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			1 - For State Registrar	State of Ma	arylan				ealth a D <i>eath</i>	ind Me	ntal Hy	giene	005	34	138
1	19 大学		Decedent's Name (First, Middle, Last)						2	2. Date of De				me of Death
140	Physici /Medic		Charles Thomas	s SI	nry,	S	Sr.			0	Month ctober	Day 10.		ar 1:3	5 A ^M
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7 0			9610 Liberty Road					eric					ederi		
	Funeral		5. Social Security Number 6. Se	x 7. Age ŬM 2□F		last birthday) Yrs.	If Unde Months		If Under 2 Hours	Min.	Date of Birt (Month, Da	y, Year)	9.	Birthplace (S Country)	tate or Foreign
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	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Ins	de City Limits
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	r 28e	Director	10e. Street and Number				10f. Zij	p Code				10g. Citi	zen of Wha	t Country?	
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	ems ems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.	S. 13. V	Was Dece	dent of His	spanic Orig	in? (Speci Puerto Ri	fy Yes or No	-		American Indi White, etc.	an,
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Maryland	d 2 should th and Men 7 Is marke treumatic		19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	ng Address	s (Street a	and Number	r or Rural I	Route Numbe	er, City o	r Town, Sta	te, Zip Code)	
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o e	Pages 1 nent of H. int: If Itel iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ f	Removal from State	20b. P	lace of Dispo emetery, crem	sition (Na natory or o	me of other place	9)	Dat	te .	20c. Lo	cation - City	y or Town, Sta	nte
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o.	at the dea by the at stached fo	SICI	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown	time of d	eath 5□	Other (s	pecify)					Month	Day	Year
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ō	Phys r this ral di	1: To	27. Manner of Death	28a. Date of Injur (Month, Day		ER/Outpatien 28b. Time of		28c. Injury		sing Home	d. Describe h	ow injur	v occurred	Specify)	
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	.1		30. Name and address of person who c	ompleted cause of d	eath (Item	1 23a) (Type.								,	
	- 1		A. Zakaria Hegazi	, MD, 46-I	3 The	mas Jo	hnso	n Dri	lve, F	rede	rick,	MD	21702		
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10	172 hours after death with the Maryland "neturel", or Itams 23a or 28e-1 show polical Expartiret must be nutified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 Yes 2 I	,	_ 13. V	Vas Decedent Yes, specify (of Hispa Cuban, N	inic Origi Jexican,	in? (Speci Puerto Ri	fy Yes or No can, etc.)	D- 1-	4. Race - An Black, Wh	rerican Indian, ite, etc.	
036	ours a	by	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Dates:	1960	1	□Yes 2	No S	specity:			5	Specify: Wh	ite	
15-("netu	ete	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced	lent's Usual Ockind of work do	ccupation	n ng most o	of working		16b. Kin	d of Busines	s/Industry	
212	d within giene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or		Mecha		швиј				Dies	sel Re	pair	
Maryland 21215-0036	ba filed tal Hygid d other event, II	Be C	17. Father's Name (First, Middle, La	st)				18.	. Mother	's Name (i	First, Middle				
ryla	2 should ba and Mental is marked c	2	Ernest Sowder	(Time Brief)		401 14 19					annama				
Ma	ad 2 st lith and 27 is r r treur		19a. Informant's Name/Relationship Barbara Golombows				g Address <i>(Sti</i> oni Cou							Zip Code)	
Baltimore,	Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant: If Ism 27 is marked other than "n ury or other treumatic event, If a Meal ury or other treumatic event, If a Meal ury or other treumatic event, If a Meal ury or other treumatic event, If a Meal ury or other treumatic event, If a Meal ury or other treumatic event, If a Meal ury or other treumatic event, If a Meal ury or other treumatic event, If a Meal ury or other treum events are used.		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name o	f place)		Dat	Θ	20c. Loc	ation - City o	r Town, State	
Ë	Pagitment tent: H		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	oify)	Vete	erans	Cemete	ry	1	0/25				Marylar	
Bal	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Irio	Mich	2	Da 40	Name and Activid J 1 Sout	Web h Ch	Facility er F este	uner er St	al Hon reet H	nes P Baltir	.A. more,	MD 21231	
Б			23a. Part 1. Enter the disease of co shock, or heart failure. List on Immediate Cause (Final	mplications that cause ly one cause on each I	d the death. ine.	Do not ente	er the mode of	dying, so	uch as ca	ardiac or r	espiratory a	rrest,		Approximate Interval Bety Onset and D	veen Neath
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as	MA S		ancer	-						month	
P	Examiner		Sequentially list conditions	b	u cons	noe or).									
7	pe tisi	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classe or injury	Due to (or as	a consequer	nce of):									
Š,	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as	a consequer	nce of):									
8760,	death certificate be executed e attending physician and of for use as the burial-transit	ō		d											
9	ertifica fing ph	an/Medic	IF FEMALE:	20 - 14								1			
Вох	death certifica attending ph d for use as the	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregna					23	3d. Date of de Month	,	ear
P.O.	that the d ed by the detached	hysici	1	9□ Unknown			- Caron (0,000m)								
Ś	S US	by P	Part II. Other significant conditions	contributing to death t	out not resulti	ng in the un	iderlying cause	given in	Part I.					to the cause of de	
Sorc	w require baen sig should b	eted									-	Yes 2			nknown
Rec	e tar has	ompieted										psy prmed2	prior to death?		variable use of
ital		Be C	25. Was case referred to medical examiner?			100	-	26.	. Place o	of Death (0	1 ☐ Yes Check only o	No No	1 ☐ Ye	s 2□No	
of Vital Record	Physicien: this certific al director,	은	1 ☐ Yes 2 ☐ No		ent 2 EF			Other:	Nurs				□Other (Sp	ecify)	
	ding h. After funer	Certification:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Inju (Month, Da	y Year)	Bb. Time of Injury		njury at Work? 1 ∐ Yes	2 □ No		d. Describe	how injury	occurred		
Division	or Attendater deatl Director: in by the	tifica	3 Suicide 6 Could not	be 28e. Place of In	ury - At home	e, farm, stre	et, factory, off	ice		28f	Location (Street and	Number or F	iural Route Numb	99 <i>r</i> ,
Ö	spitel or Atten ours after deat terel Director; filled in by the		6												
	of the Se	dical	29a. Certifier Certifying I (Check only one)	Physician: To the best aminer: On the basis of and manner st	it examination	edge, death n and/or inv	occurred at the estigation, in n	e time, d ny opinio	date and on, death	place, and occurred	d due to the at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1				ense nu				29d. Date	signed (Mon	th, Day, Year)	
)	1		· Jos 1	tou	- u	1.0	De	0	55	03	5	10/	19/03	5	
	31		30. Name and address of person wh	700- 1	leath (Item 2	3a) (Type, I	Print)	2	/ [43 -	. ^		. 5-	
	Sta	ite	31-Date filed (Month, Day, Year)	3 Registr	ar's Signatur	6 VTN	Slud.	Da	1+11	200	- 10	4	212	-18	
1	Registr		OCT 2 1 2	005 House	ar's Signatur	A									

			1 - For State Registrar	State of	Maryland			t of H	ealth a	and M	-		005	3616	n
			1. Decedent's Name (First, Middle	a, Last)							2. Date of De	ath		3. Time of Dear	th
	Physici /Medic		Lorraine			Se	xton				Octobei	20,	2005	8:44 A	М
	Examin		4a. Facility Name (If not institution	, give street and numb	er)		4b. City,	Town, or	Location	of Death		4c. (County of Death)	
			3010 Wells Ave	nue				geme:				1	Baltimo	re	
	Funeral Director		5. Social Security Number 215–28–5387	6. Sex 1 ☐ M 2 ☒ F	Age (In yrs. Ia		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month Da April	22,19	9. Birth Cou	place (State or For intry) ID	eign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Lin	nits
	f aho	ō	MD. Balt	imore		Edgen	ere							1 ☐ Yes 2 💢	No
	288 288	rec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Cou	intry?	
	3a or		3010 Wells Aven	ue			2	1219				USZ	A		
	ma 2	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13.	Was Deced	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 1	4. Race - Amer		
9	or its	E	1 Never Married 2 Marr	ied 1 ☐ Yes 2 If Yes, Give	®S / No	1	_				Hican, etc.)		Black, White		
ဗ္တ	ours raf,	d by	3 Widowed 4 □ Divorced	Year or Date	es:		1 🗆 Yes	20110	Specify:				Specify: Wh	nite	
21215-0036	be filed within 72 hours after deeth with the Maryland lat Hygiene. d other than "natural", or itama 23e or 28e-f ahow avent, the Medical Examinativat by motified at	Completed	15. Deceden (Specify only highe:	t's Education st grade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	nk done d	ition <i>furing mos</i>	t of work	ing	16b. Kir	id of Business/ii	ndustry	
12	withir sne. than	ш	Elementary/Secondary (0-12)	College (1-4	or 5+)	10			_			D-14	imore (14 4	
	e filed withln al Hygiene. I other than '		12 Years 17. Father's Name (First, Middle,	Last)		Mai	ntena	nce			e (First, Middle			ııcy	
an	d be ental cad o	To Be	Albert Szambors						Mar	ianne	e Szamb	orski	<u>L</u>		
Maryland	should be nd Mental markad	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City or	Town, State, Zi	p Code)	
	t and 2 s Health ar em 27 is wher trau		Timothy W. Sext	on so	n						gemere,				
Baltimore,	ges 1 and 2 should it of Health and Men if item 27 is marks or other traumatic		20a. Method of Disposition	0.75	Ce	ace of Dispo	sition (Nar	ne of ther place	9)	Octo	ober	20c. Loc	cation - City or T	own, State	
<u>Ĕ</u>	Pag nent ant: if		1 ☑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		Sacn	ed Hear	t of J	esus (Jem.¦	24,	2005	Dund	alk,MD.		
alt	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service	Licensee	00) 2	Name ar	Addres	s of Facilit	¥1 Ho	ome Of 1	Dunda	alk,P.A.		
_	20E = 9		Munon	y con	nelle	1 7	110 S	olle	rs Po	oint	Road,	Dunda	alk,MD.		
	Pnysician		23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition	pomplications that cau poly one cause on eac	h line.	fate		e of dying		and		rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):		(1						
		١,	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ience of):									
7	ted nsit	in in	Cause (Disease or injury	\$ 500.00 (6)	ao a concequ	101100 017.									
Ć	e be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):									_
8760,	sate be executed thy sician and the burial-transit	call		d.											
õ		pa	I S S S M M S												
Box	death certifical attending play for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar		Ectopic pr	ecnancy				2	3d. Date of deliv		
Э.		Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		t at time of de		Other (sp						Month	Day Year	
P.O.	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant condition	ins contributing to deal	th but not resu	ulting in the u	nderkina c	auce awa	n in Part I		23a Didit	abacco us	se contribute to	the cause of death	7
ds,	signed be dei	d by			//	morra		Dis	era		1 🖫			bably 4 □Unkno	
cor	w requir been si should	ieted	Huneste	byfructuy nowi			0		-		24a. Was	an	24b Were aut	opsy findings availa	able
Record	0 <u>c</u> 0	ompi	Huserely	blisterens							autor perfo	osy rmed?	prior to co death?	ompletion of cause	of
Vital		e C	25. Was case referred to medica						26. Place	of Death	1 Yes	22 No	1 🗆 Yes	2 No	
\leq	S S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 🗆 E	ER/Outpatier	nt 3 DC	Othe	ar.		/		Other (Speci	fy)	
n of	ding Ph h. After th funeral		27. Man or of Death 1 Natural 5 Pendir	28a. Date of (Month,	Injury Day Year)	28b. Time o	f 2	8c. Injury Work	at		28d. Describe l	now injury	occurred		
sio	Attanding ir death. actor: After by the fune	catic	2 Accident Investi	gation			М		res 2□	No					
Division	- a	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place of	Injury - At ho , etc. (Specify	me, farm, st	reet, factory	, office			28f. Location (3 City or Tox	Street and vn, State)	Number or Rur	al Route Number,	
	Hospital of the hours at Funaral Distriction filled it	Ce	29a. Certifier 1 Certifyir	o Physician Tasks	ant of muclim	wlades de :	h os	na ab *	n detc :	d ala	and direk "				
	To the Hospital of within 24 hours aft To the Funeral completely filled in	ledical	(Check only 2 Medical one)	g Physician: To the be Examiner: On the basi and manne	is of examinat	ion and/or in	vestigation	, in my op	oinion, dea	id place, ith occurr	ed at the time,	date and	place, and due t	o the cause(s)	_
	To To Con	Σ	29b. Signature and title of certifie			^	290	: License	number			29d. Date	signed (Month,	Day, Year)	
•	7		nonved C		NOW	0	U	-28	509	1		10	1000)	
() <u>-</u>	10		Ronard Arr	mad Asia	of death (Item	Phile	Print)	plu	n R	el. S	wite #1	08	Bolt. H	5 D. Z123	7
E.	Sta Registi		31. Date filed (Month, Day, Year)	2005	istrar's Signat	erure		,							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artment of Hea ertificate of De	Ith and Menta	al Hygien Reg. N		34141
3	Physici	an	Decedent's Name (First, Middle, Las				Mo		ay Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	TUCKER		4b. City. Town, or Loc		0 19	Ic. County of Death	1
. 9	Examin	er		ITAN HOSI	PITAL	BAITI	MOLE		c. County of Death	!
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday		Under 24 Hrs. 8. Da	te of Birth onth, Day, Yea pt. 7, 1	9. Birth	place (State or Foreign
2	Director		213-22-0002	©M 2□F 78	Yrs.	Months Bays 11	Se	pt.7,1	927 Mai	ryland
	land w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Mary F-f sh	tor	MD Baltin	ore		Essex				1 Yes 2 No
	in the	Director	10e. Street and Number			10f. Zip Code		10g. C	Citizen of What Cou	intry?
	23a c	raiD	302 Nickelsor	Ave.		2122	1	U	JSA	
36	ges 1 and 2 should be itied within 72 hours after death with the Maryland tof Heelth and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, Mo 1 ☐ Yes ♣️ No Sp	nic Origin? (Specify Ye exican, Puerto Rican, pecify:	es or No- etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	edent's Usual Occupation a kind of work done during		16b.	Kind of Business/Ir	
215	within 7 ene. than "n	Completed	(Specify only highest gra-	de completed) College (1-4or 5+)	life.	DO NOT use retired)			parrows	
	filed wi Hygien other th		10th		N	laintenanc				FOIIC
Maryland	buld be fill Mental H arked ott atic even) Be	17. Father's Name (First, Middle, Last) John Calvin	Tucker			Mother's Name (First, Margaret			
2	2 should be and Mental is marked of eurnatic ev	ပ္	19a. Informant's Name/Relationship (7		19b. Mail	ing Address (Street and f				c Code)
_	1 and 2. Heelth ar em 27 is		Theresa J. Tuc	ker /wife		02 Nickel				· · · · · · · · · · · · · · · · · · ·
ore,	of He of He		20a. Method of Disposition 1 ★ Warrial 2 □ Cremation 3 □		b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date		Location - City or T	
Ĕ	Peges ment of I tent: If Its jury or o		4 Donation 5 Other (Specify) H		llCemeter		05 Ba	ltimore	e MD
Baltimore,	permit. Peges 1 a Department of Hee Importent: If Item eny Injury or othe		21. Signature of Funeral Service Licen	M Conn	elli 2	2. Name and Address of 300 Mac	Facility Conne			eofEssex
ń			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the di pre-tause on each line.	eath. Do not en	iter the mode of dying, su	ch as cardiac or respi	ratory arrest,		Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition resulting in death)	a SEPTICS						Onset and Death SHOUKS
4000	/Medical Examiner		1	Due to (or as a cons	sequence of):	- 40000	11.14	10		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of):	E NOUCH	INAZ /	NIEC	21CH	
$\sqrt{}$	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.					10	
, O	e exerien ar urial-t	Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
68760,	icate be executed physicien and s the burial-transit	edicai		d						
P.O. Box 6	To the Hospitel or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
ď	signed by	by Ph	Part II. Other significant conditions co	ontributing to death but not	resulting in the (underlying cause given in	Part I. 23	Be. Did tobacco	use contribute to t	the cause of death?
Records,	w requires been sign should be							1 ☐ Yes	2 □ No 3 □ Prol	bably 4 Unknown
000	e law re has bee je 2 sho	Completed					24	a. Was an autopsy	24b. Were auto	opsy findings available
č	The ate ha	Com					10	performed?	death?	empletion of cause of 2 No
/ita	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Place of Death (Chec			
5	ding Physician: The Ih. Ater this certificate ha funeral director, page	. To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	28b. Time of		□ Nursing Home 5	Residence		fy)
o	ding th. After	ition	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes		sacribe flow in	ury occurred	
Division of Vital	Atter or dea octor by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, office			and Number or Run	al Route Number,
	itel or rs afte el Dir led in	Cert						y or Town, Sta		
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, dea ination and/or in	th occurred at the time, da evestigation, in my opinion	ate and place, and due n, death occurred at th	e to the cause(ne time, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License nun			ate signed (Month,	
1			Habed Sudma	MP		01930	07	10	9/20/05	
	10			completed cause of death (I	Item 23a) (Type	Print) COCH RA	ula Dina	RA-	mall M	A014 - 10210 =
-	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sir	gnature .	LOCK FA	VEN BLVD	DALI.	MORE [//	LICANIS IST
	Regist			2005 Mague	15.	Gener				

			rieasi	Otata of Marila				-	_	
			1 For State	State of Maryla					^ ~ -	01.1.5
			Registrar		Cei	tificate of		Reg. I	2005	34/42
*	Physici /Medi		1. Decedent's Name (First, Middle, I	J. TERRY				2. Date of Death Month	2009	3. Time of Death
	Examir		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town, or	Location of Death		4c. County of Deal	th MARE
, di	Funeral		5. Social Security Number 6.		. last birthday)	If Under 1 Year	Under 24 Hrs.	B Date of Birth (Month, Day, Yea	9. Bin	thplace (State or Foreign
	Director		229-32-0764 Usual Residence of Decedent	18M 20F 73	Yrs.	Months Days	Hours Min.	FEB 24,	1932 VI	RONA
	Marylan f show	or	10a. State 10b. County	10c. C	By Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number		111111111111111111111111111111111111111	10f. Zip Code		10g. (Citizen of What Co	
	23a o	Funeral Director	1203 57,1	4GNES LAN	E	212	207		4.9,A	,
	tems	nne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
Baltimore, Maryland 21215-0036	rit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23s or 28s-f show injury or other traumatic event, the Medical Examinar must be notified at injury or each other traumatic event, the Medical Examinar must be notified at 8.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		☐ Yes 2☐ No			Specify. Ph	ack
7	natu dical	etec	15. Decedent's (Specify only highest of	Education grade completed)	(Give	ent's Usual Occup	during most of working	16b.	Kind of Business/	Industry
12	e filed within al Hygiene. I other than vent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. A	NOT use retired	Tinh	2	BUI /DIA	16
9	i Hygi other	Be Co	17. Father's Name (First, Middle, La	st)		VIIIC	18. Mother's Name	First, Middle, Maid	en Sumame)	
ılar	uid be Mentai irked o	To B	WESLEY 15	KRV			ALICE	G1/VII	27	
lar	2 should and Men Is marke surnatic	y 14	19a. Informant's Name/Relationship	(Type Print)	19b. Mailin	g Address (Street	and Number or Rural	Route Number, City	y or Town, State, 2	Zip Code)
S,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.		KAMCIA A. II	YHOR	Place of Dispo	MAIDRO	DK KB	MALTIMO	1/1/1/ In	21229
Jor	Pages nent of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cren	natory or other place	(a) 10 14	10 20c.	Location · City or	Town, State
턡	artme ortani injury		4 □ Donation 5 □ Other (Special Signature of Maneral Signature)		447/4/	Name and Address	ss of Facility	10 / ///	11/4/47	5 00mm 1000
Ba	permit. Departm Importa any inju		Jank (1 M)	mel	/	MR 18 1	OMORIA TIL	RESERVED TO	No FA	2124
*			23a. Part. Enter the hisease, in co shoot, or leart failure. List on	implications that caused the dea	ith. Do not ente	er the mode of dyin	ig, such as cardiac or	respiratory arrest,	1K_ 11/1	Approximate Interval Between
	Physician		Immedia a Cause (Final disease condition	_a. ESOPHOGEAL						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						
	LAGITITIE	L	Sequentially list conditions,	b. — Directo (or as a consec	cuciones off.					<u> </u>
Т	ned	Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cina to for as a conser	quarica oi):					
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o.	0 0	ysic	1 Yes 2 No 9 Unknown	4□Pregnant at time of o	death 5	Other (specify)				ŕ
<u> </u>	s that ned b e deta	by Pt	Part II. Other significant conditions	contributing to death but not re-	sulting in the ur	iderlying cause givi	en in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
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ecc	e law re has be ge 2 sho	Completed						24a. Was an autopsy	24b. Were au	topsy findings available
<u>ح</u>		Con						performed? 1 Yes 2 X N	death?	completion of cause of 2 No
Vita	ilcien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospitali			26. Place of Death			
	Phys this or	. To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatien 28b. Time of		4 U Nursing Hom			cify) HOSPICE
on	Attanding Physicien: r death. sctor: After this certific by the funeral director,	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury	28c. Injun Work	yat k? Yes 2 ☐ No	ld. Describe how in	farA occassed	
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Ö	Hospitel or 14 hours afte Funeral Dir tely filled in I			Dullding, etc. (Speci				City or Town, Sta	110)	
	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my of	ne, date and place, ar pinion, death occurred	id due to the cause I at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of cartifier	and marrier stated.		29c. License	e number	29d. D	Date signed (Mont)	h, Day, Year)
)	>F 0		102			Du	3725		10/201	/
	\cap		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type, I	Print)	J - J		. 9/ - 5/	
	7		DR. TARIQ MAH			LEY RD.	TIMONIUM,	MD 21093	3	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					

DHMH 17 Rev 1/2001

1:40 a.m.

OCTOBER 20, 2005

WILBERT TERRY

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-27-05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar 05 Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1150 A M read well October 18 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner stor torc Kuan If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 2707 **Funeral** Min Months Days Hours 1□M 2 F Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 XNo MD Director Hartoro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Eventher Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No ö Specify: If Yes, Give ✓ Year or Dates: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) nonemaker NWO other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be 12 should be fi 2 Joseph Voci Eleanor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health 1344 Ruanko, Fallston bhn Iread we 2104 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ō Department of Important: If any injury or ' 4 □ Donation 5 □ Other (Specify) 10-20-05 Forest Hill EVANSFUNERALCHAPEZ-22. Name and Address of Facility FOREST HILL, MD 21050. 21. Signature of Funeral Service Ligensee EVANS FUNERAL CHAPEZ-BELAIR BREWPORTDE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Ust only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Wonsmall celllung carcinoma Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (alequate or injury) Due to (or as a consequence of): Examiner ician and burial-transit Cause (Liesane or injul that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate 1 Yes 2**X)** No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatrent 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral L 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier λle the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO051770 October 20 2005 Walemer V of person who completed cause of death (Item 23a) (Type, Print) MD 1650 CreansStreet Baltimore Mar land 21231 Juke Brak 31. Date filed (Month, Day, Year) OCT 2 1 2005 . Registrar's Signature Registra State Registrar

			For State Registrer		Maryland		artment of tificate of			Reg. No		34144	
Ī	Physici /Medic	al	Decedent's Name (First, Middle, Mary Frances 4a. Facility Name (If not institution,	Truslow	her)		Ab City Town	or Location of E	Octo	ober 17		3. Time of Death $11:05\text{A}^{\text{M}}$	
	Examin Funeral Director	er	Prince George's	Hospital		st birthday) Yrs.	Chever 1 Year Months Day:	- Y r If Under 24	Hrs. 8. Date		ince Ge		
re, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 721s marked other than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evertiner must be notified at once.	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's		Town or Lo	cation Heights					10d. Inside City Limits 1 ☐ Yes 2 No	
		Funeral Director					10f. Zip Code 2 0 7 4 7				. Citizen of What Country? U.S.A.		
		þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Ford	No	'	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 💢 No	ban, Mexican, P	n? (Specify Yes ⊇uerto Rican, e	or No-	14. Race - Ame Black, White Specify: B		
		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual O (Give kind of work diffe. DO NOT use in Domestic					ccupation (one during most of working atired)			Kind of Business/Industry Domestic		
		To Be Co	17. Father's Name (First, Middle, Last) Henry Green					Mary	8. Mother's Name (First, Middle, Maiden Sumame) Mary E. Owens				
			19a. Informant's Name/Relationsh Ruth Toles (Nie 20a. Method of Disposition	ece	20b. Plac	6602	Evanstor	St., D		t Heigh	or Town, State, 2 Lts, MD 2 ocation - City or	20747	
Baltimore,			20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Date 20c. Location - City or Town, State										
	Enysician /Medical		23a. Pakt. Enter My disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Approximate Interval Between Onset and Death Ons										
Hecords, P.O. Box 68/60,	ate be executed whysician and purial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PNE Due to (o	r as a conseque	nce of):							
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify)								23d. Date of delivery Month Day Year		
	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in OLD CEREBRAL VKS CULAR ACCIDENT						23e		Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown		
	aing Physician: After this certifications of the director, is	Completed by							1 🗆	. Was an autopsy performed? Yes 2 K No	prior to death?	topsy findings available completion of cause of	
		ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig									Sify)	
DIVIS	ospital or Attano hours after death unaral Diractor: ly filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	building, etc. (Specify) 289. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) City or Town, State)						9)			
	To the Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)									to the cause(s)	
	1		1 Berlin De					55703				D5 MD 20785	
	Sta	to.	30. Name and address of person of TS/ON BERHAN 31. Date filed (MATT) Day (Year)	JE, MD.	٠	3001		TAL Z	DR .	CHE	VERLY,	MD 20785	
	Registr		DOLVE I	2003	gistrar's Signatur	Agen							

			For State	State of Ma	-	epartmer Certifica			d Me		0.0	0 5	21.1	1 5
			Registrar 1. Decedent's Name (First, Middle,	Last)		Joranica	07 2	Call		Date of Deat		0.0	3. Time of	f Death
·	Physici: Medic/		NORE	J.		TENNEY				ОСТОВЕ	R 78,	2005	6:15	Рм
/ I	Examin	ier	4a. Facility Name (If not institution,	-		4b. City	, Town, or I	Location of D		-	4c. Cour	nty of Death	TMORE	
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	uneral irector		219-10-4288	1□M 2√F	80 Y	Months	Days		Vlin.	Date of Birth (Month, Day, SEPT.30	1925	Cou	olace (State ontry))
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er des	Hems Der m	nuel	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dece If Yes, spe	dent of His	panic Origin' n, Mexican, P	? (Specif uerto Ric	y Yes or No- can, etc.)		ace - Ameri lack, White,		
U K I K I D-0050 filed within 72 hours after death with the Maryland Hygiene.	or or	by F	1 ☐ Never Married 2 💢 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	0	1 🗆 Yes	2 X No	Specify:			Spec	cify:	WHIT	ſΕ
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ithin 16	han a	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. DO NOT i	ise retired)	mig most or	working					
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yrar buld be Mental	if item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Madical Examinar must be notified at	To Be	OLLIE		J	0SEPH		CLAR		asi, miccio, n	naiden dann		ILVERM	1AN
2 should and Men	e ma	-	19a. Informant's Name/Relationshi			Mailing Addres		nd Number o	r Rural F			m, State, Zij	Code)	
end :	if item 27 or other tra		C. FRANK TENN	EY / HUSBAND	_	210 MII		D ROAD						
See 1	or of		20a. Method of Disposition 1	B □Removal trom State		crematory or	other place		Date		20c. Location			
Daliting permit. Pages Depertment of	Important: i any injury o once.		4 Donation 5 Other (Special Signature of Juneral Solvice Li		BALTIMO	22. Name a				LEVIN:			OWN, M	
	any ir		Mulhau	Dung	2-					OAD -				
			23a. Parl . Enter the disease, or c shock, or heart failure. List o	omplications that aused in	the death. Do no	t enter the mo	de of dying	, such as car	rdiac or re	espiratory arre	est,		Approximat Interval Bet	le lween
	sician		Immediate Cause (Final disease or condition	_ a.	BROAS			, ne					Onset and	Death IVS.
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de et	he ette ed for	sicia	in the past 12 months?	1□Live birth 2 4□Pregnant at t 9□ Unknown		3 ∐Ectopic p 5 ☐ Other (s					A	Month	Day '	Year
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	artifice actor, p	Be C	25. Was case referred to medical examiner?					26. Place of	Death (C	Check only one		1 1 1 43	20 140	
OI VIKA Physician:	this or	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital:		patient 3 D		4 Nursir		5 Reside			y)	
2 2	After	tlon	1 Natural 5 Pending			ury M	28c. Injury Work′ 1 □ Y	at ? es 2 □ No	280	d. Describe ho	w injury occi	urred		
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DIVISIO To the Hospital or Attendi within 24 hours efter death.	To the Funaral Director: After this cardificate hes completely filled in by the funeral director, pege 2.	edical	29a. Certifying (Check only one)	Physician: To the best of xaminer: On the basis of	examination and/	death occurred or investigation	at the time	e, date and pi	lace, and	d due to the ca at the time, da	iuse(s) and rate and place	manner as s e, and due t	tated. the cause(s	s)
o the	o the	Med	29b. Signature and title of certifier	and manner stat	ed.		c. License				d. Date sign			·
) - s			1GC				12	773	0				200	5
	1		30. Name and address of person w		ath (Item 23a) (T	ype, Print)				1				
سني	1		31. Date filed (Month, Day, Year)		9 W -	ype, Print)	051	- 1	401	THOM	5, 11.	1 21	204	
	Sta Registr		OCT 2 1 2	1005 Hegistra	r's Signature	and I								

05-7023 B.K.S HAROLD VON VANPELT 3RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () () 5

For State Amend Item 281 per me 6849 11-15-05 tas
Registrar Registrar Registrar 34146 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HAROLD VON VAN PELT, III OCT. 16, 0128 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ROUTE # 220 SOUTH @ CHAT & CHEW McCoole ALLEGANY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 30,1972 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 XM 2□ F 32 234-31-1431 Cumberland, Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County I? Ie marked other then "natural", or Items 23a or 28a-f ebov treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MDAllegany Rawlings 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 23628 McMullen Highway, S.W. 21557 USA deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other treumstic event, Lie Madical Exemptions. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Journeyman Iron Working 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Von VanPelt, Jr. Janet Faye Rhodes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. & Mrs. Harold VanPelt/Parents 23628 McMullen Highway, S.W. Rawlings, MD 21557 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Dawson Cemetery Dawson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street 26726 Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE INTURIES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Sua to for as a contemuance of Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). 68760 Physician/Medical use as the Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ es 2 ☐ No 24a. Was an this certificete Yes 2□No Vital Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one/ Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 MOther (Specify) AT SCENE 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending FLOTORCYCLE INVOLVED INCOLLISION 1 Yes 2 No death. 1:25 AM To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A investigation 10116/05 2 Accident filled in by the 6 Could not be determined 3 Suicide 28! Location (Street and Number or Rural Route Number, City or Town, State) Rt. 220 S. At. Chat And Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ROAD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E OCT. 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n MNA 111 PENN STREET, BALTIMORE, MARYLAND 21201 RUBIO, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 2005 Registrar

			For S State Registrar	-	artment of Health and Me rtificate of Death	ental Hygien Reg.	11115	34147
			Decedent's Name (First, Middle, Last)	, , ,		2. Date of Death Month Da	Vaar	3. Time of Death
	Physicia /Medic		Shirley Wi	right		Oct 18	2005	4:32 PM
	Examin		4a. Facility Name (If not institution, give street Bon Scrout	of and number)	4b. City, Town, or Location of Death	re	c. County of Death	
	Funeral Director	9	5. Social Security Number 6. Sex	7. Âge (In yrs. last birthday) 22 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year (D), 19, 9	9. Birthp Cour 56 Ma	
	yland iow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L			1	0d. Inside City Limits
	the Mar 28a-f st	ector	10e. Street and Number	/A E	altimore 101. Zip Code	10g. C	itizen of What Cour	1 ⊠ es 2 □ No
	ath with s 23a or ust be	Funeral Director	1509 Press	er Court	21217	afty Vec or No	U.S.	A pan Indian
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, the Modical Examinational parallised at	by Fune	1 Never Married 2 Married	Armed Forces?	Was Decedent of Hispanic Origin? (Spet If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	ciry fes of No-	Black, White,	
21215-0036	in 72 ho n "natur Medical	Completed by	15. Decedent's Educati (Specify only highest grade co	College (1-4or 5+) (Give	edent's Usual Occupation a kind of work done during most of workin DO NOT use retired)	g	Kind of Business/In	,
	e filed within all Hygiene.		17. Father's Name (First, Middle, Last)	NA mai	interance WM 18. Mother's Name	(First, Middle, Maide		
Maryland	ould be f Mental I arkad ol atic eva	To Be	Robert	wright	Edn	a K	ane	
Mar	nd 2 shou lith and M 27 is marl r traumati		19a. Informant's Name/Relationship (Type, Sherita Harr	Print) 196. Maili	ing Address (Street and Number or Rura) Presser ct. Ba	Houte Number, City	/	Code)
altimore,	Pages 1 and intent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 → Gurial 2 □ Commation 3 □ Rem 4 □ Donation 5 ⊅ Other (Specify)	20b. Place of Disposer cometery, cre	osition (Name of product) Omatory or other place) Wary Cem. 10/2	2/05 20c. I	en Bew	own, State
Baltir	permit. Pages Department of Important: If I any njury or ence.		21. Signature of Fineral Service License	1 2	2. Name and Address of Facility	ictor Pa	SS	1 2000
		H	23a. Par 1 Enter the alsease, or complicat	ions that caused the death. Do not en			ne sain	Approximate Interval Between
	Physician		shock or yeart failure. List only one of Immediate Cause (Final disease of condition		orbation			Onset and Death
E	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
V	sit 9d	lner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence of):				
° 0	siclan and burial-transit	Exam	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
09289	icate b physic s the bi	edicai	d.	W- 4 2			11:	
O. Box (The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
<u>а</u>	es that the igned by be detact	by Ph	Part II. Other significant conditions contrib	outing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	~/	the cause of death?
ecords,	w require been si	eted				24a. Was an		opsy findings available
$\mathbf{\alpha}$; The law cate has b r, page 2 s	Completed				autopsy performed?	prior to co death?	ompletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	pital:	26. Place of Death			
of	Physi this o	٦.	1 Yes 2 No	1 Impatient 2 LEN Outpatie		ne 5 Residence 28d. Describe how in		fy)
	Jing After fune	tion	1 ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury			•	
Division	P Hite	Certification:	C C Could not be	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and City or Town, Sta		al Route Number,
_	To the Hospital or At within 24 hours after of To the Funaral Dirac completely filled in by	edical Co	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	ian: To the best of my knowledge, dea :: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, and place, investigation, in my opinion, death occurred	and due to the causer ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier	Polit mo.	29c. License number 29c. 29c. License number		Date signed (Month,	Day, Year)
•	5		30./Name and address of person who com	pleted cause of death (Item 23a) (Type	D0052950 Baltin		nd 2	1223
	St	ate	31. Date filed (Month, Day, Year) OCT 2 1 2005	3. Registrar's Signature		,	,	
	Regist	rar	001 % 1 2000	MANUAL DE 199				

			1 - For State Registrar	State of Ma	aryland .	/ Depa	artment of H tificate of I	lealth and Death	l Mental Hy	giene Reg. No.	005	34148
	Physici	an	Decedent's Name (First, Middle	•					2. Date of Do	eath Day	Year	3. Time of Death
	/Medic		Phyllis Mildre						Octobe	r 18	2005	12:45 p M
	Examin	ner	4a. Facility Name (If not institution				4b. City, Town, or	r Location of De	ath		County of Dea	
30	Funeval		Greater Baltimo 5. Social Security Number		enter e (In yrs. last	birthday)	Towson If Under 1 Year	If Under 24 H	rs. 8 Date of Bi	Ba1	timore	thplace (State or Foreign
	Funeral Director		215-18-9226		83	Yrs.	Months Days	Hours Mi	n. March	Y Year) 9	22 Ma	irviand
75	2		Usual Residence of Decedent		· · · · ·							
zely.	show H	<u>_</u>	10a. State 10b. County	2.	10c. City, T							10d. Inside City Limits
Ž	8a-f	ecto	Maryland N/	A	Dd	ltimo						1 (X)Yes 2 □ No
allylatic ZIZI3-0030 should be filed within 22 hours after death with the Marvland	f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Mcdical Examiner must be notified at	Funeral Director	10e. Street and Number 4310 Valley Vie	w Avenue			10f. Zip Code 212	06		-	en of What C USA	ountry?
dea	tams	uner	11. Marital Status	12. Was Decedent I Armed Forces?		13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	o- 14	4. Race - Am	
o affe	o.	by Fi	1 □ Never Married 2 □ Mar 3XXWidowed 4 □ Divorced	If Voc Cino	10		I □ Yes 2/□ No	Specify:		5	Specify: Wh	
3 3	tural E			Year or Dates:	1 1	6a Decer	lent's Usual Occup	ation		,	d of Business	
i c	n ne	Completed	(Specify only highe	st grade completed)		(Give	kind of work done of NOT use retired	during most of w	rorking	TOD. NIN	u or business	vindustry
אַ ער אַ	r tha	E O	Elementary/Secondary (0-12)	College (1-4or 5		Homer	naker			0wn	Home	
2	otha otha vant,	Be C	17. Father's Name (First, Middle,	Last)	· ·			18. Mother's N	ame (First, Middle	, Maiden S	lumame)	
6	Menta urkad utic e	70 E	Martin Emerick					Lettie	Hughes			
	and I Is me		19a. Informant's Name/Relations		1	19b. Mailin	g Address (Street a	and Number or F	Rural Route Numb	er, City or	Town, State,	Zip Code)
≥ ⊤	ealth m 27 nar tr		Michele Conne	r /Daughter			Valley Vi	ew Aven		imore		1206
Des 1	If ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	ceme	etery, cren	sition (Name of natory or other plac		Date		ation - City or	
altillo	tmen tant: vjury	1	`4 ☐ Donation 5 ☐ Other (S				Forest V	1	/24/05	Owin	gs Mil	1s MD
	Department of Healt Important: If itam 2 any injury or othar once.		21. Signature of Funeral Service	Walte	L. Hil		eopard J. F 305 Harford	KUCK. INC.	iltimore Ma	aryland	1 21214	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each lin	10.	Do not ente	er the mode of dying	g, such as cardi				Approximate Interval Between
Pi	nysician		Immediate Cause (Final disease or condition	2	my	Itipl	e Wgen	faine				Onset and Death Zd445
	Medical xaminer		resulting in death)	Due to (or as a	a consequen	ce of):						2017
_	Adminer	_	Sequentially list conditions,	b	01-1	<u> </u>						
pe	sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequent		0.4 /					
icate be executed	physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequence	ce of):	2747					
	siciar buris	alE										
		edical		d								
S d	signed by the attending d be detached for use a	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Catania assessa			23	d. Date of dei	livery
deat	ne atte	sicla	in the past 12 months?	4☐Pregnant at			Ectopic pregnancy Other (specify)				Month	Day Year
at the	by the	hys	9 🗆 Unknown				335-035					
es th	igned be de	by	Part II. Dther significant condition	ons contributing to death bu	ut not resultin	g in the un	derlying cause give	en in Part I.				the cause of death?
	been si	ted							10	Yes 2□	No 3∏Pr	obably 4 Unknown
ne taw	certificate has b	Completed							24a. Was autor perfo	osy ormed2	24b. Were au prior to death?	utopsy findings available completion of cause of
1 : E	ar death. Yector: After this certificate his by the funeral director, page	CO	25. Was case referred to medica	1				OS Place of Dr	1 Yes	2 No	1 🗆 Yes	2 No
/sicig	s cert	o B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatier	nt 2∏ €R/	Outnatient	3□ DOA Othe	_	eath <i>(Check only c</i> Home 5 Resid		Other /Sne	cifu)
2 4	er thi	n: T	27. Manner of Death	28a. Date of Injur	y 28t	b. Time of	28c. Injury Work	at	28d. Describe I			chy,
ig u	ath. vr: Aft ne fur	atlo	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	gation	1 bar/	Injury		r res 2 □No				
r Atte	recto	ertification;	3 Suicide 6 Could determ		ry - At home, . (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and I vn. State)	Number or Ru	ural Route Number,
اق د	rrs aft ral Di	O										
To the Hospital or Attanding Physician: The law requires that the death certification	within 24 hours after death. To tha Funaral Director: After this completely filled in by the funeral dir	edical	29a. Certifier 1 ▼ Certifyir (Check only one)	ng Physician: To the best of Examiner: On the basis of and manner stat	examination	dge, death and/or inv	occurred at the time estigation, in my op	e, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) ar date and pl	nd manner as lace, and due	stated. to the cause(s)
Tot	To t	Σ	29b. Signature and title of certifie	A.	-		29c. License	-			signed (Monti	
	_				1 · D			3654				9,2005
	5	261	30. Name and address of person		eath (Item 23)	a) (Type, F	St # 20	3, B46				
il.	Sta		31. Date filed (Month, Day, Year)	2005 . Registra	r's Signature	Coas	رع					
	Registr	dl	OCT 2 1	COOD CONTRACT	d 550 B		×					

CCTOBER 18, 2005 & 7:20AM

WYCHE, JOE

		1 - For State Registrar		ertificate of Death	Reg.	2000 34149
Physici /Medio Examir	cal	Decedent's Name (First, Middle, La Joe W. Wyche 4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Dea	October 18,	2005 3. Time of Death 7:20 A
Funeral Director		Stella Maris Luthervil 5. Social Security Number 6. S 218–42–5479		Lutherville If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Forei Country) North Carolina
death with the Maryland ms 23s or 28s-f show	rector	MD 10b. County NA 10e. Street and Number	10c. City, Town or L	Baltimore	100	10d. Inside City Limit 1)∑Yes 2 □ N Citizen of What Country?
is I and 2 should be lied within 72 hours after death with the Marylar of Health and Mental Hygiene. I then 21 is marked other than "natural", or Items 23a or 28a-1 show then 21 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. The Modical Examiner is unit to invitilled at	by Funeral Director	1610 E. 28th Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates:	21218 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		USA 14 Race - American Indian, Black, White, etc. Specify:
illed within 72 ho Hygiene. Ither than "natur Int. Ine Ned Call	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12	de completed) (Give life.	odent's Usual Occupation a kind of work done during most of wi DO NOT use retired) aborer	orking 16b.	Black Kind of Business/Industry Construction
z should be file and Mental Hy is marked oth aumatic event	To Be (Father's Name (First, Middle, Last) Wyche Informant's Name/Relationship (1) 				en Sumame)
rage nent c ant: If ary or		Jacqueline Wyche/Wi 20a. Method of Disposition 1 Burial 2 remation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	fe 1610 Removal from State (r) 20b. Place of Dispresentery, cre Mt. Zion (E. 28th Street Balto esition (Name of matory or other place)	, MD 21218 Date 20c.	Location - City or Town, State
hysician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not en one cause on each line.	rlie Funeral Home P.A ter the mode of dying, such as cardia ASCULAY AC	ac or respiratory arrest,	r Street Balto, MD 212 Approximate Interval Between Onset and Death
xaminer			Due to (or as a consequence or):			
nysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
y the attending physician and ached for use as the burial-transit	cai	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence or): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
een signed by the attending physician and nould be detached for use as the burial-transit	by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence of): d. 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	Other (specify)		Month Day Year use contribute to the cause of death?
ate has been signed by the attending phy age 2 should be detached for use as the	e Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy Dive birth Diversity Diversity Diversity Diversity Diversity Diversity Dive	Other (specify)	24a. Was an autopsy performed?	use contribute to the cause of death? Unknow 24b. Were autopsy findings availab prior to completion of cause of death?
this certificate has been signed by the attending phy at director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as a consequence or): d. 23c. If yes, outcome of pregnancy 1	Other (specify) Inderlying cause given in Part I. 26. Place of Deat 3 DOA Other: 4 Nursing F	24a. Was an autopsy performed? 1 Yes 2 No.	Month Day Year use contribute to the cause of death? □ No 3 □ Probably 4 Munknow 24b. Were autopsy findings available prior to completion of cause of death? □ □ Yes 2 □ No
ath. 7. After this certificate has been signed by the attending phy ne funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence of): d. 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown ontributing to death but not resulting in the u Hospital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, str building, etc. (Specify)	Other (specify) 26. Place of Decay at 3 DOA Other: 4 Nursing Financial Work? M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed? 1 Yes 2 No. ath Check only one tome 5 Residence 28d. Describe how injuication 28f. Location Street a. City or Town, State	Month Day Year use contribute to the cause of death? Unknow 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Mother (Specify) HOSPICE
n 24 hours after death. Ne Funeral Director: After this certificate has been signed by the attending phy pletely filled in by the funeral director, page 2 should be detached for use as the	ledical Certification; To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as a consequence or): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	Other (specify) 26. Place of Dec. ot 3 DOA Other: 4 Nursing Fig. 28c. Injury at Work? M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed? 1 Yes 2 No. ath Check only one 28d. Describe how injuiced at City or Town, State 28d. and due to the cause(surred at the time, date an autopsy performed)	Month Day Year use contribute to the cause of death? Day Year use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Day Other (Specify) POSPICE Orly occurred

State of Maryland / Department of Health and Mental Hygiene

			Clair of	iviai yiai io	•	tificate o	f Death		Reg. NO. ()	15 0	1 150
	1. Decedent's Name (Firs	t, Middle, Last)						2. Dete of D	eeth CU	13 Vs.	Time of Dealb
Physician	Henry All	len Broo	oks					Octobe	r 15, 20	005 12	2:15 AM
/Medical Examiner	4a Fecility Neme (If not in			er)			4b. City, Town, or	Location of Dee			
	Genesis I	Loch Ray	7en				Baltimo	ore			
Funeral	5. Sociel Security Number	r 6. Sex	7.	Age (In yrs. le	st birthdey)	If Under 1 Ye	ar If Under 24 Hrs	8. Date of Bi	rth	9. Birthplace	(State or Foreign
Director	400-28-2341 Usuel Residence of Dece		M 20 F	84	Yrs.	Months Day	s Hours Min.		1, 1921	Country) Kentud	cky
the Maryland rotified at rector		County	-	10c. City,	Town or Loc	ation					nside City Limits
e Ma	MD Ha	rford		F	orest	Hill				1	☐ Yes 2√ No
offer death with the Mark frems 23e or 28a-fe or or 28a-fe or or and the most free Funeral Director	10e. Street end Number					10f. Zip Code			10g. Citizen of \	_	
230 unit b	713 Walter	s Mill	Road				21050		U	ISA	
ter dea trems iner m	11. Maritel Status		12. Was Decede Armed Force	ent Ever in U,S	. 13. W	as Decedent o	f Hispenic Origin? (Suben, Mexican, Puer	Specify Yes or N	o- 14. Rac	e - American Inck, White, etc.	dian,
ors efter Examine by Fu	1 Never Married 2 3 ☑ Widowed 4 □ D	_	1 X Yes 2 If Yes, Give Year or Date	□No	1	□ Yes 2√√ N		to ritoan, etc.,	Specify		e
thurs		ecedent's Educ		1743	16e. Decede	ent's Usuel Occ	cupation		16b. Kind of Bi	usiness/Industry	,
and 2 should be filed within 72 hours efter death with the Maryland halfh and Mentel Hygiene. 27 is marked other than "naturel", or flems 23e or 28e-f show er traumatic event, the Madical Examiner must be notified at To Be Completed by Funeral Director	(Specify only Elementery/Secondary	ly highest grede	completed) College (1-4	or 5+)	(Give k	ind of work do O NOT use ret	ne during most of wo	rking		,	
Co retail	12		0		macl	ninest				pers	
Be est H	17. Father's Neme (First,								, Maiden Surnan	10)	
Men Men To To	William He						Lollie	e Mae Al	len		
2 sh end ie m	19a. Informant's Name/Re	elationship (Ty	oe, Print)		19b. Mailing	Address (Stre	et and Number or Ri	urel Route Numb	per, City or Town,	State, Zip Code	9)
end ealth n 27	Judith Ha		ıghter		21 Gr	een Lea	ıf Road Ba			234	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mentel Hygiene. Important: If item 27 ie marked other than "naturst", any Injury or other traumatic event, the Madical Exi ance. To Be Completed by	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crer 4 ☑ Donation 5 ☐ C	mation 3 🗆 R	emoval from Sta	000	ce of Dispos netery, cremi	ition (Name of atory or other p	elace)	Date	20c. Location -	City or Town, S	State
permit. Departm Importa any Inju	21. Signature of Funeral S Rona	Service License	ade, Di	rector			ress of Fecility tomy Boar		. Baltim	ore Str	eet
	1 mi	2011	11/1/18	REC		ltimore					
	23a. Part1. Enter the dise shock, ir heart failu	ease, compli re. List only on	e cause on eecl	h line.			ying, such es cardia	- /	Δ.	Inter	roximate rval Between et and Death
Physician /Medical	Immediate Ceuse (Finel		C1	ron	1/1	pstv	uctive f)u(mor	ary Di	Sease_	et and Death
Examiner	disease or condition resulting in deeth)	е		•	es a consegu		ord 1		J .	-	
D ## D				Due to (or e	a consequ	erice or,				1	
rificate be executed no physicien and set the buriel-trensit	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	is,	•	Due to (or e	s e consequ	ence of):					
ficate be e physiciens sthe buri	that initieted events	٥		Due to (or a	is e conseque	ence of):					
ding ph se es th	resulting in death) Lest				·	·					
at the daath ce d by the attendi lateched for use Physician/							,				
the day	Part II. Other significant of	-		11 .	7		given in Part I.	23b. Did	tobacco use cor	atribute to the	cause of death?
es that the igned by be dated by Ph		Can	CRY	071	ons	ur		1 🗆	Yes 2□ No	3 Probably	4 🗆 Unknown
v requires that the daath ce been signed by the attendir should be dateched for use leted by Physician/I					U				an autopsy ormed?	available	utopsy findings e prior to tion of cause
The law requir sate has been s page 2 should								Greek Control		of death	17
icate									Yes 2XINc	1 ☐ Yes	2 💢 No
iclan: certific rector	25. Was case referred to examiner?	-	ospital:			_ (ath (Check only			
this c el dir	1 ☐ Yes 2 Ñ No 27. Menner of Death	1	1 ☐ Inpa		R/Outpatient 8b. Time of	3 DOA	46 Nursing F		idence 6 Othe		
ing f	1 🕅 Netural 5 🗆	Pending	(Month,	Dey Year)	Injury	28c. In W	ork? □Yes 2□No	200. Describe	now injury occurr	eu	
tor: / tha	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	29a Place of	Injury - At hom	o form stro			29f Location	Street and Numb	or or Pum/ Pou	te Number
tal or Attending P rs after deeth. el Director: After t led in by the funere Certification:	4 Homicide	determined		etc. (Specify)	ie, iami, stree	et, ractory, ome	e		wn, Stete)	er or nurer nou	te ivumber,
To the Hospital or Attending Physician: The law requires that the daath certificate be within 24 hours after deeth. To the Funeral Director: After this certificate hes been signed by the attending physicie completaly filled in by tha funeral director, page 2 should be dateched for use as the bur Medical Certification: To Be Completed by Physician/Medical	29a. Certifier 17 C (Check only one)	ertifying Phys ledical Examin	cian: To the be er: On the besis and menner	s of exeminatio	edge, deeth o n end/or inve	occurred at the estigation, in m	time, date end place opinion, death occu	and due to the urred et the time,	ceuse(s) and ma date and place, a	nner as steted. and due to the o	cause(s)
Me apple	29b. Signature end title of	certifier	and member	stated.	1	29c. Lice	nse number		29d. Date signed	d (Month, Dev.	Year)
E3E8	> Whi	- A	tten	lings-	145.	Zan	053	642	Oct	182	005
	30. Name and address of	person who con	npleted cause o	of deeth from 2	3e) (Type, P		VS 30	3 Bal	1+:a0	212	39
State Registrar	31. Date filed (Manth Bay		35 Regi	strer's Signatur	To Sass	Les .		, ,			//

Regi DHMH 16 Rev 6/95

fony Braks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#19a, perFH, C848, 10/24/05 II

State of Maryland / Department of Health and Mental Hygiepe 0 5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** BARNES JUSTINE 8:37 PM OCTOBER 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Hospital Baltimore City The Johns NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 216-62-0321 11-14-53 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23s or 28a-f show othar traumatic avant. The Medical Eraminar must be notified at Yes 2□No Completed by Funeral Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 1136 Gorsuch Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be tiled within 72 hours after trent of Health and Mental Hygiene. Thent of Health and Mental Hygiene. Strt: If item 27 is marked other than "natural", or Ital 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Housekeeping Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Wood Evelyn Jesse 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1136 Gorsuch Avenue, Baltimore, Md. - Husdand Stephen Barnes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Deportment of H
Important: If ite
any njury or of 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Garrison Forest Vet. 10-26-05 Owing Mills, Md. 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ventilator Associated disease or condition resulting in death) /Medical **Examiner** Respiratory Distress Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Acule Renal Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ţō Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s 1 Yes Division of Vital Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28b. Time of Injury 28c. Injury at Work? Certification: 27. Magner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai within 24 ho To tha Fun completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res - 000 MEDICAL DOCTOR October 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 600 North Wolfe Street, Bultimore Maryland 21287 The Johns Hopkins Hospital 4 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Victore Bradio :10AM 0 xtotox 1900 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ohns Hopkins Baysew are Cole Cole Balkwore Baltmore If Under 1 Year | If Under 24 Hrs. **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, JULY 18 Birthplace (State or Foreign Country) 1931 Days Hours Min. 1 → M 2 □ F 216-28-1977 Director 74 MD. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. Its Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD. BALTIMORE PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5040 CLIFFORD ROAD 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify. 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene." 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 10TH METER READER BGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be it. Pages 1 and 2 should be f rtment of Health and Mental H rtant: If item 27 is marked of MICHAEL BONADIO GENEVA TREGO 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN BONADIO/WIFE 5040 CLIFFORD ROAD, PERRY HALL, MARYLAND 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 10/17/2005 BALTIMORE, MARYLAND permit.
Departr
Importe
any inju 21. Signature of Euneral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician 9 disease or condition resulting in death) ay how /Medical Due to (or as a consequence of) Examiner mpdus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TYTTY Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760. Physician/Medical BY MEDICAL EXAMINER IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 0 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 25. Was case referred to medical locas 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: director 26. Place of Death (Check only one) examiner? 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 2 Accident 3 Suicide essell ten 10:00 AM 1 ☐ Yes 2 No investigation 1-611 Director in 24 hour. the Funeral Directory of the Funer 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Mary MODIFICEDIA Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SOOS, OK TOOLES impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh PAC 5505 Hopkins Bayonew PEER am south ore, MD 2334 torn iennive, gistrar's Signature 31. Date filed (Month, Day, Year) OCT 2 4 Registrar

	1	For State Registrar	State of Mai	•		ment of H iicate of L		-	giene Reg. No. 0	5 34153
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Examine	r '	Battimove Rehabis 5. Social Security Number 6. Se	litation Ex	lended C	CV2	Balti Under 1 Year	Location of Death MOTE If Under 24 Hrs. Hours Min.	8. Date of Bir	th	Birtholace (State or Foreign
Director		219-38-4437 11	©M 2□F 6	11.	Yrs.	onths Days	Tiours Will.	Aug .	5,1341	Karyland
aryland show		10a. State 10b. County		10c. City, Towr						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the Ma	Director	Maryland Carrol 10e. Street and Number	l-	WEDL	mins	10f. Zip Code			10g. Citizen of W	
23a or		410 Poole Rd. Apt	. T3				157		U.S.A	
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	Be	17. Father's Name (First, Middle, Last) Robert Bennett					18. Mother's Name	e (First, Middle rtha	, Maiden Sumam	e)
y, Maryland and 2 should be file eath and Mental Hy n 27 is marked oth her traumatic event	<u>٩</u>	19a. Informant's Name/Relationship (1 Kimberly Bennett -					and Number or Run	al Route Numb		
Baltimore, Marylar permit. Pages 1 and 2 should b Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic e once.		20a. Method of Disposition 1 ⊞ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify			ry, cremate	ory or other plac	:e) !	Date 26,20		City or Town, State
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he Hospi n 24 hou he Funer pletely fill	edlcal	(Check only 2 Medical Exar	niner: To the best of the basis of and manner state	examination an		tigation, in my o	pinion, death occur		date and place, a	and due to the cause(s)
To	Σ	29b. Signature and title of certifier	Will	M		29c. Licens	1365		Octob.	ev 21, 2005
3		30. Name and address of person who Gabyge E. Wi	completed cause of de	ath (Item 23a)	(Type, Pri	och Ro	aven Bo	ulevan	d, Balt	move, MD zrz
Stat Registra	te ar	31. Date filed (Month, Day, Year) OCT 2 4	2005 32. Halistra	r's Signature	A	arti				

ysicia	an_	1 - State Registrar 1. Decedent's Name (First, Middle, La:	State of Marylar	Ce	rtificate of		2. Date of Death	Day Year	3 4 5
/ledic		Eva		Bruc	T		October	17 2000	
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	Director	MD Montgo	nery G	aither	sburg				1 ☐ Yes 2√
	<u> </u>	10e. Street and Number			10f. Zip Code	20077	10g	. Citizen of What C	Country?
	erai	301 Russell Av	12. Was Decedent Ever in U	IS 13	Was Decedent of H	20877	Specify Yes or No-	USA 14. Race - Arr	perican Indian
	by Funeral	1X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	an, Mexican, Puer Specify:	to Rican, etc.)	Black, Wh	
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	To B	John Bruck				Len	а Нерр		
		19a. Informant's Name/Relationship (Beverly Bachmann/			-		ural Route Number, C altimore,	•	_
ODCE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specify	Removal from State		osition (Name of matory or other plac	ce)	Date 200	c. Location - City o	r Town, State
once.		21. Signature of Funeral Service Licer Ronald S	ISOO	r S	2. Name and Addrest tate Anat altimore,	omy Boar	d 655 W. E	Baltimore	Street
an cal		23a. Pant. Enter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	rdias	ter the mode of dyin		c or respiratory arrest,		Approximate Interval Betwee Onset and Deat
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	by	Part II. Other significant conditions of Hypothersion	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobac		o the cause of death
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5		27. Manner of Death 1 Patural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred						
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6	C 2	29a. Certifier 1 Certifying Ph	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death occu	e, and due to the cause irred at the time, date	e(s) and manner a and pla <i>ce</i> , and du	s stated. e to the cause(s)
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			For State Registrar	State of Ma	•	artment o ertificate o		nd Mental Hyg	giene 19. 2005	34155
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Yvonne Bolz						15, 2005	10:30 PM ^M
1	Examir	er	4a. Facility Name (If not institution, give s		nter		m, or Location of er Sprin;		4c. County of Dea	
			Arcola Nursing & 5. Social Security Number 6. Sex		e (In yrs. last birthda			4 Hrs. 8. Date of Birtl		thplace (State or Foreign
	Funeral Director			M 2∏F	85 Yrs.	Months Da	ays Hours	Min. (Month, Day May 18,	1920 Vi	ountry) rginia
	ס		Usual Residence of Decedent							
	urylan show	_	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Sct	MD Montgomen	ry	Takom	a Park	4-		log. Citizen of What C	
	with the	ä	10e. Street and Number	2110		10f. Zip Cod	2091	1	USA	ountry?
	filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or items 23a or 28e-f show that the Mudical Examiner: usite Indiffied at	Funeral Director	7051 Carroll Aver	2. Was Decedent	Ever in U.S. 13	. Was Decedent				erican Indian,
'	fter d	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X	No			n? (Specify Yes or No- Puerto Rican, etc.)		
93	ursa al'.o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:		Specify: Ţ	white
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anc	d be f	Be	Emerson W. Giles					rest Gayle	,	
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≥	and 2 sealth ar		Steven Bolz/son		P.O.	Box 77	0555 Lak	kewood, OH	44107	
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Baltimore,	permit. Pages 1 a Department of Hes Important: if item any injury or othe		21. Sign turn Huneral Service License	A LOVE	etar	22. Name and Ad State A Baltimo	natomy Facility natomy Fre, MD	30ard 655 W	. Baltimor	e Street
	/Medical Examiner	xaminer	23a. Part Enter the disease, or complication of heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cereb Due to (or as	ral infarc a consequence of): a consequence of): a consequence of):					Interval Between Onset and Death
Vital Records, P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions conditions	4 Pregnant a 9 Unknown tributing to death b	2 Fetal death 3 t time of death 5 out not resulting in the		e given in Part I.		_	Day Year
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Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ini	iury - At home, farm,		1 □ Yes 2 □ N	28f. Location (S	treet and Number or R	ural Route Number,
Ď	after Direct	ertif	4 Homicide determined	building, et	c. (Specify)	,,		City or Tow	n, State)	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exemin	sicien: To the best ner: On the basis of and manner st	f examination and/or	ath occurred at th investigation, in r	ne time, date and my opinion, death	place, and due to the coocurred at the time, co	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	n	1	29c. Lic	cense number	261	9d. Date signed (Mon	th, Day, Year)
)			1 Com of	Rosa l	Lin	(D52	061	10-17	-05
			30. Name and address of person who co	mpleted cause of	death (Item 23a) (Typ	e, Print) Q		1 0:	, , ,	2.9.0
			alan Kicha	rape	pl,	pu	ver	spring	, ma	20107
	Sta Regist		31. Date filed (Month Day Year)	82. Registr	ar's Signature	sul!		1		

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State Registrar Dr. Wassin 31. Date filed (Month, Day, Year)

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2005

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Books

Hitti 9000 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie () 5 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Carter 2005 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8421 Maryland Road Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Year) Days Min. 1 ☑ M 2 ☐ F 217-16-1367 82 Feb. 04 1923 Director MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "netural", or Items 23a or 28a-f show It e Medical Examinar must be multied at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8421 Maryland Road 21122 USA filed within 72 hours after death Hygiene. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Depertment of Health and Mental Hygient Important: If Item 27 Is marked other the any injury or other traumatic event, ILE. Once. 6 Truck Driver Tractor Trailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Philip Κ. Carter Victoria Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Carter 8421 Maryland Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct. 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 2005 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** muntrs metastatic bladder cuncr disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has autopsy 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) Certification: To 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No investigation 2 ☐ Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number DO57936 10/24/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUMB 900 CUM AN EM 900 Ceutin Avenue Bathmore nuo 21229

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Registrar

31. Date filed (Month, Day, Year)

OCT 2 4 2005

ROBERT CREIGHTON Unpend item#23a, 27, 28a-1, perME, G849, II/16/05 TT
State of Maryland / Department of Health and Mental Hygiene 05 - 7139ADH Reg. 2.005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert. Physician OCTOBER CREIGHTON 0805 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months 217-80-3471 Director January 20, 1960 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Mudical Examiner must be notified at Baltimore 1 Yes 2 No Completed by Funeral Director DUN dalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene.
Is marked other than "natural", or Iteme 23a or ? 21222 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) an employed UNEMPloyeD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Creighton W.115 JOAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 Is 1 R 10926 BIREUSTONE

200. Place of Disposition (Name of cemetery, crematory or other place) narles - Brother Kiley Hagers town mi other Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Important: If It any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dak Lawn Cemekey 10

22. Name and Address of Facility

Brad 1 - ASK 4 ☐ Donation 5 ☐ Other (Specify) 10 124/05 21. Signature of Funeral Service Lice see Funeral Home 1ey - Askton WILLOW ODRING Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Cocaine and narcotic intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1/□ Yes 2 □ No 24a Was an autopsy performed? certificate 1 Tes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA After thi 28a. Date of Injury Pnd Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred unk Certification: 5 Pending investigation 1 Natural death. 7:28 1 ☐ Yes 2 XNo 10-22-05 within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident A 6X Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number St. City or Town, State) 2700 PlayTield St. 4 - Homicide found in park (Heritage Park) Dundalk, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number OCME 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTOBER 23, 2005

State Registrar 31. Date filed (*Month, Day, Year*)

OCT 2 4 2005

ITEUDORE

2. Registrar's Signature

30. Name and address of person who completed cause of gleath (Item 23a) (Type, Print) 111 Penn Street

Baltimore, Maryland 21201

ADH Amend item#19a, perFh, 6848, 10/24/05 TT State of Maryland / Department of Health and Mental Hygien 0 5 TYRONE R. DORSEY 05-7115 34159 1 - For Stata Ragistrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** OCTOBER 20. R. Dorsey 2005 1505 Tyrone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA UNION MEMORIAL HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8-6-53 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**☆**M 2□F Days Md. Director 219-62-0792 52 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at Md. NA Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 permit. Pages 1 end 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a eny injury or other traumatic event, tra Medical Examinar must once. 3119 Barclay Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NA Disabled llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Banks Anna W. Dorsey, Sr. Charles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna Dorsey 3119 Barclay Street, Baltimore, Md. Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐Other (Specify) 10-26-05 King Mem. Park Randallstown, Md. 21. Signature of Poneral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Work-million March F.H. East 1101 E. North Ave. Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** TORSION OF SMALL ROWEL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as guipo IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy atter for u Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Nes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) X Yes 2 □ No 2 this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manngir of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a 799 Confiler Certifying Physiciam: To the best of my knowledge, death conurred at the time, data and place, and due to the cause(s) and manner as stated To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check only one)

29b. Signature and title of certifier

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31. Date filed (Moh) Dy, 2014 2005

(m)

34 Pegistrar's Signature

29c. License number OCME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

21, 2005

OCTOBER

Amend item#20a C22, per Frint in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 0 0 5 34160 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 11, 2005 10:21 AM **Physician** Nobuko Duggan /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 3934 Rickover Road Kensington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country)
 Japan 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🛱 F Yrs. Apr 19, 1937 Director 219-64-3643 68 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Kensington MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20895 USA 3934 Rickover Road Items 23e Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter anent of Health and Mental Hygiene. It item 27 is marked other then "natural", or ite any or other treumatic avent, the Neulical Examina 1 Never Married 2 Married asian 1 ☐ Yes 2 🎇 No Specify Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home housewife 12 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) unk Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8104 Spruce Valley Lane Clifton, VA James Duggan/former husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Crematory 10/21/05 Baltimore, MD

22. Name and Address of Facility Hartley Miller-Stellas F/H

Baltimore, ND 212017527 Harford Rd Baltimore, MD 4 Donation 5 Chor (Specify) in State Bayview Crematory 21. Signature of Funeral Service Lice Ronald S Wade, Di 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approxima 21234
Intervat Between
Onset and Death Immediate Cause (Final disease or condition ARTERIOSCUESMOTIC CARDIOUASCULAR **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day jo 5 ☐ Other (specify) detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Nnknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 DXNo 1 Yes 2 🗆 No 1 ☐ Yes certificate or Attending Physician: 25. Was case referred to medical examiner?

1 2 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manger of Death 28b. Time of After 1 Aatural 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed/(Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 10/17/05 0015236

Registrar DHMH 17 Rev 1/2001

State

THIS REGIONICE PIPE, ROCKILE IND 20051

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2005

32. Registrar's Signature

LARL 31. Date filed (Month, Day, Year)

I.

State of Maryland / Department of Health and Mental Hygien 2005 1- State Amend Item 18 per fh G849 11-2-05fite at of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 20, 2005 5:05 P.M CALVIN LAWRENCE FICKETT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GLEN MEADOWS HEALTH CARE CENTER GLEN ARM BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Hours Months 1 🕱 M 2 🗆 F MAINE 006-12-2571 6/24/1922 Director Usual Residence of Decedent 10d, Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-1 ehow the Modical Examiner must be notified at 1 Yes 2 No BALTIMORE GLEN ARM MD Director 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 9 APT. L-25 21057 USA 11630 GLEN ARM ROAD or itams 23a death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Ø Yes 2 ☐ No If Yes, Give Year or Dates: ₩WII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3 Widowed 4 ☐ Divorced "naturel", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) ARMY CORP. OF College (1-4or 5+) Elementary/Secondary (0-12) ENGINEER **ENGINEERS** t. Pages 1 and 2 should be filed without of Health and Mental Hygie trant; If Item 27 le marked other talury or other traumatic event, ID. 18. Mother's Name (First, Middle, Maiden Sumame)
Shannahan
DORIS SHANNON 17. Father's Name (First, Middle, Last) CALVIN L. FICKETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2104 EDGEWARE ST. SILVER SPRING, MD DAVID FICKETT/SON Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department o Important; if eny injury or once. METRO CREMATORY, INC. 10/24/05 CATONSVILLE , MD 4 □ Donation 5 □ Other (Specify) 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CLOSTRIDIUM Immediate Cause (Final disease or condition resulting in death) DIFFICILIZ O DAYS **Physician** /Medical Examiner PHEJMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine YSPIHAGIA to the Hospital or Attending Physician: The law requires that the death certificate be executed buriaj-transit and Due to (or as a consequence of): RROVASCULAR ACCUBRY Box 68760. Completed by Physician/Medical attending pt for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, , ALZHEIM ERSTYPE DEMENTA 1 Yes 2 No 3 Probably 4 Unknown DIFEASE SALKINGONS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EN/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours efter To the Funeral Dire Securifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/21/2003 RAMANT GOPALVAN MD 30 Name and address, of person who completed cause of death (Item 23a) (Type, Print)

RAM AND HOPALAN MD LE. RULLING (ROSS ROPE) #159 BATIMORE MD 21228

State Registrar

31. Date filed (Month, Day, Year)

Eleva & Spell

		4	For L_ State			d / Depa		Health and	Mental Hy	2005	34162
			Registrar 1. Decedent's Name (First, Middle, Last)			061	unicate or	Death	2. Date of De.		3. Time of Death
	Physicia		August John Geph	ardt. Sr					Octobe	r 24, 2005	
	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City, Town, o	or Location of De		4c. County of De	
	Examin	EI	Stella Maris Hospi				Timoniu	ım		Balt	imore
2.	Funeral		5. Social Security Number 6. Sex	N 2015		last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	h y, Year) 9. B	inthplace (State or Foreign Country)
â	Director	-	213-34-9021	M 2UF	69	Yrs.			Feb.11	,1936 Ma	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Many f sh	to	Maryland		Bal	ltimore)				1 XX es 2 ☐ No
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	Country?
	th wit	Funeral Director	4413 Powell Avenue				2120			U.S.A.	
	tama tama	nue	11. Walital Olatos	12. Was Decedent Armed Forces?		.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - Arr Black, Wh	
36	rs aft	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	40		1 ☐ Yes 2 ☑ No	Specify:		Specify: W	hite
Š	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f show tha Modical Examinar mand be notilliad at	ted	15. Decedent's Edu (Specify only highest grade	cation	-	16a. Dece	dent's Usual Occu kind of work done	pation	vorkina	16b. Kind of Busines	s/Industry
21	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	ed)	9	Trucking	
2	ygien ygien har th	S	0			Driv	er.	18 Mother's N	lame /First_Middle	Maiden Sumame)	
and	I be fi	To Be Completed	17. Father's Name (First, Middle, Last) George Gephardt						Laubach	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Ž	thould Me and Me mark	۲	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Maili	ng Address (Stree			er, City or Town, State	, Zip Code)
<u>≅</u>	nd 2 s lith ac 27 is r trau		Harry Gephardt (Br			1313	Mohrs La	ne, Bal	timore, M	aryland 21	220
ē,	f Heal	j	20a. Method of Disposition		20b. F	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location - City of	or Town, State
Ë	Page nent o int: If iry or		1X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	Oal	k Lawn	Cemetery	oct oct	.27,2005	Baltimore	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hyglene. Important: if Itam 27 is marked other than "netural; or Itama 23s or 28s-f show way fujury or other traumatic avant, Ita Macical Examinar mant be notified as Once.		21. Signatura of Funeral Service Lons	90		2:	2. Name and Addr E	ess of Facility Bruzdzin	ski Funer	al Home. P	.A.
	#9 = 9		THE		<u> </u>						.A. yland 21221 Approximate
П			23a. Part1. Ferst the disease, or compl shock, or reart failure. List only o	ne cause on each i	ne.		er the mode of dy	ing, such as care	iac or respiratory a	riest,	Interval Between Onset and Death
4	Physician /Medical		Immediate Qause (Final disease or condition resulting in death)	Due to (or as							
П	Examiner			D06 t0 (01 as	a consec	(derice 01).					
		je	Sequentially list conditions, if any, leading to immediate cass. Liner fundarying Cause (Disease or injury	Due to (or as	a consec	quence of):					
k,	cuted nd ransit	Examiner	that initiated events	2.							
760,	ie be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consec	quence of):					E
687	physic physic the b	dical		J							
Вох	law requires that the death certificate as been signed by the ettending phys 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			-			23d. Date of d	telivery
	death e ette d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Dectopic pregnant Other (specify)	су		Month	Day Year
P.O.	at the by the tache	hys	9 Unknown	9□ Unknown							
	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death I	out not res	sulting in the t	inderlying cause g	iven in Part I.		tobacco use contribute	Probably 4 Munknown
of Vital Records,	requir				-				-		-
Sec	ne law has b ge 2 st	Completed							- 24a. Was		autopsy findings available o completion of cause of ?
a H	T age			_					1 □ Yes	2 X No 1 Y	es 2 No
ΖË	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	iont 2] ER/Outpatie	nt 3 DOA		Death Check only		Decity) HOSPICE
of	Phys or this oral di	1 - 4	27. Manner of Death	28a. Date of Inj (Month, Di	ury	28b. Time	-			how injury occurred	Soony, HODI IOI
ion	Attending I r death. ector: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mortin, Di	ay 10ai/	Injury		Yes 2 No			
Division	for Attendation of the Attendati	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In			reet, factory, office	9		Street and Number or wn, State)	Rural Route Number,
۵	urs afte			atatam Tariha basa		and the day		to an idea of the	and this to the	and the same of the same	no status
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edicai	(Check only 2 Medical Exam	iner: On the basis and manner s	of examin	ation and/or i	nvestigation, in my	opinion, death o	ccurred at the time	date and place, and d	lue to the cause(s)
	within 2 To the complet	₩ W	29b. Signature and title of certifier				29c. Lice	nse number		29d. Date signed (Mo	
)	- > - 0		10.)4372	-i	10/24	1/05
•	9		30. Name and address of person who o	ompleted cause of	death (Ite	m 23a) (Type	, Print)	,	C		
			DR. TARIQ MAHMOO	D 2300 I	DULAN	EY VAL	LEY RD.	TIMONIU	M, MD 21	093	
· e	St Regist	ate rar	31. Date filed (Month, Day, Year)	.32. Regis	uars sign	latule	A. J.				
		- 3	COL W T COO	44							

12:50 a.m.

OCTOBER 24, 2005

AUGUST GEPHARDT

State of Maryland / Department of Health and Mental Hygiere 0 05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** Oct. Gerling 21 Viva Marie 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2nd Street Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) May 31, 1950 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Days Hours 212-58-8600 55 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f ehow 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No Director Pasadena Md. Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ir than "natural", or Itams 23a or 8295 Waterford Rd. 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ğ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other trearmatic event. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Household 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Flmer ပ္ Breneman Haze1 Milholland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heath Gerling (Son) 3802 2nd st.Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Oct. 24 2005 Crownsville. Md. 4 □ Donation 5 □ Other (Specify) Md._Veterans_Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 ns tilt caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final Prysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed use as the burial-transit iding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant detached for us 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 2 No 1 Yes Hospital or Attanding Physician: 44 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 No Residence ို 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 🚛 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier us D. 10.24.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pasadence MO. 2 112 desor 3708 Mountain Rd Aristophe 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie2005Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** SR. 1:13)cto ber 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Head are 7. Age (In yrs. last birthday)
Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) **Funeral** 6408 binuary 26, 1936 VIRGINIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or itema 23a or 28a-1 ahow traumatic event, the Modical Examinat must be notified at 1 Yes 2 No BALtimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 225No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ AFRICAN AMERICAN 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO/NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Depertment of Heath and Mental Hy Important: if item 27 is marked other any Injury or other traumatic event, 0068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be dia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elmont Altimole, MARGHAN 21216 Kimberly 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition , Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 Doration 5 Other (Specify) 22. Name and Address of Facility Lancy M. WALLace Fureral School 21. Signature of Funeral Service Licensee 3405 W. FRANKIN St. BAHIMORE, MARY AND 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MINUTES **Physician** /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-translt Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1YPRRTRNSION 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 21 NO the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident 24 hours after deat a Funerel Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fund completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar DHMH 17 Rev 1/2001 57

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005 Registrar's Signature

MARLES

D0051865

MUSPITA

GNRS

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** , 2005 October 7 9:45 PM M Joseph Galante /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Holy Cross Rehab & Nursing Center Burtonsville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1₩ 2□F Months Director Dec 17, 1911 285-34-2332 Italy Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a, State 10b. County or then "natural", or Items 23a or 28a-f show the Medical Examinar must be multipled at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Montgomery Burtonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20866 3415 Greencastle Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) baker confectioneries 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental Hient: If item 27 is marked other Justina Venditti Vincenzo Galante 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3412 Greencastle Road Burtonsville, MD 20866 Anna Liebling/daughter item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite sny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 Donation 5 ☐ Other (Specify) 21. Signature of Pogeral Service Licensee Ronald S Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia days **Physician** /Medical Due to (or as a consequence of): Examiner ment Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transft The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Armstrong, N.O. 1420/ Lawrel Ple. Pr. #102 Laurel, MD 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 4 2005 Registrar

			For State Registrar	State of Ma	aryland		artment of I			_	giene Reg. No.	005	3416	56
	División:		1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of	
	Physici /Medio		Betty Jane Kowe						-4 D4h	10	20	200		PM
4	Examir	er	4a. Facility Name (If not institution,	11		. 1	4b. City, Town,	1	of Death			AIT	MORE	
	Formul				e (In yrs. la	ast birthday)	If Under 1 Year	If Under		8. Date of Bir			hplace (State or	r Foreign
	Funeral Director		216-28-7210	1 □ M 20 XF	73	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da Jan. 2	, 1932	2 Mar	yland	
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	ocation						10d. Inside Cit	v Limits
	show	5	Maryland Baltimo	nre			River						1 🗆 Yes	
	28a-1	rect	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	ountry?	
	3a or	Funeral Director	2167 Graythorn I	Road			2122	20				U.S.	Α.	
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Decedent of If Yes, specify Cub	Hispanic Or van, Mexica	rigin? (Spi	ecify Yes or No Rican, etc.)	- 14	4. Race - Ame Black, Whit		
36	or Ite	by Fu	1 Never Married 2 Marrie	d 1 □ Yes 2 🔀 If Yes, Give	No	į	1 ☐ Yes 2 ☒ No					Specify: Wh	nite	
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 show deal Expressor institue reditied at	q pa	3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		16a, Dece	dent's Usual Occu	pation			16b. Kind	d of Business/		
15	nin 72 n "na	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give life.	kind of work done DO NOT use retire	during mos ed)	st of work	ing				
212	giene giene er tha	Completed	7	- Concept (1 401)		Home	emaker					n Home		
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	ist)					er's Nami lah	e (First, Middle	, Maiden S	umame)		(Unk)
Maryland	d Men narke	ပို	John Tracey 19a. Informant's Name/Relationshi	(Tuna Print)		19h Maili	ng Address (Stree			al Route Numb	er City or	Town State	Zin Code)	(0121)
Ma	id 2 sh th and 27 is r traur		Sandra Kowell (1				7 Graytho)
	s 1 an f Heel ftem 2 other		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of matory or other pla	ice)	ī	Date	20c. Loc	ation - City or	Town, State	
Ë	Page net o int: If		1 Burial 2 Cremation 3				Cemetery		ct.2	4,2005	Balti	imore,	Marylar	ıd
Baltimore,	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show important of the restition at once.		21. Signature of Funeral Septice Li	censee		2	2. Name and Addr B1	ůžďži	hski	Funera	al Hor	ne, P.A	A.	
80	205 29		77				1407 old	Easte	ern A	venue,	Essex	k, Mary	rland 21	
			23a. Party. Enter the disease, or coshock, or heart failure. List of	omplications that caused by one cause on each li	ne.	. Do not en	er the mode of dy	ing, such as	s cardiac (or respiratory a	irest,		Interval Bety Onset and D	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SepTi	<u> </u>	hoc	K						12 Ho	urs
	Examiner			Due to (or as	m n n	ience or):							12 Ho	rance.
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as		ence of).							110	10.524
X	cuted nd ransit	Examiner	that initiated events	с.										
0	cate be executed oblysicien and the burial-transit	Exi	resulting in death) Last	Due to (or as	a consequ	ence of):								
8760;	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transit	dicai	•	d										
9 X	that the death certifics ed by the attending pl detached for use as t	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	ncy					23	3d. Date of de	livery	
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 4□Pregnant a			⊒Ectopic pregnand ☐ Other (specify) _	су				Month	Day Y	'ear
0.	t the c by the tached	hys	9 Unknown	9□ Unknown										
s, P	uires that signed b	ру Р	Part II. Other significant condition	s contributing to death t	ut not resu	ilting in the u	inderlying cause g	ven in Part	I.				o the cause of de robably 4 □U	eath? Inknown
ord	w requir been si should	ted								1 🗆				
Records,	law asb 2 sl	Completed								24a. Was auto		24b. Were at prior to death?	utopsy findings a completion of ca	ause of
al F	The ete							00 Flor	4 Dans	1 ☐ Yes	2 X No	1 🗆 Yes	2 □ No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 E	ER/Outpatie	nt 3 DQA	har		h <i>(Check only o</i> me 5 ☐ Resi		Other (Spe	ecify)	
o	무 무 등	n: To	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o		attributed .	-	28d. Describe			,,	
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investiga	ition			M 1[Yes 2]No					
Division	or Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of In building, e	jury - At hor tc. (Specify	me, farm, st	reet, factory, office)		28f. Location (City or To	Street and wn, State)	Number or Ri	ural Route Numi	ber,
	Hospital of hours all Funeral D	Ce	29a. Certifier 1 Certifying	Physician: To the best	of my know	wledge deal	h occurred at the	me date a	nd place	and due to the	cause(s) a	and manner as	s stated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical E	vaminar: On the bacic of	of avaminat	ion and/or in	vectination in my	oninion de	ath occur	red at the time	date and r	place, and due	e to the cause(s))
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1			29c. Licer	se number			29d. Date	signed (Mont	th, Day, Year)	
) Call	Midst	8	MD	Print) Liv Squ	ES (000	0	10,	10110	>	
	3		30. Name and address of person w	no completed cause of	death (Item	23а) (Туре	Print)		h .	v) 17			010	27
			DR. CARI Mide 31. Date filed (Month, Day, Year)	12/02 900	20 Fr	RANK	IN SEU	ARE	UR.	DAIII	mon	E Md	1 212) /
	Sta Regist			105 Marie	, As	A. Care	W.							
		¥	001 % 1 20	CO PORTERIOR STA		-								

BETTY Kowell

			1 - For State Registrar		State	of Maryla	and / Depa	artment			and M	ental Hy		2005	31,167
			Registrar 1. Decedent's Name (First,	Middle, Last)				inout		, out, ,		2. Date of De	eath		3. Time of Death
	Physici	an		Keh1							1	Month 1 O-	-19 -		8:20P M
1	/Medi		4a. Facility Name (If not ins		street and n	umber)		4b. City,	Town, or	Location o	of Death			County of Deal	
	Examir	ıer	Suburban Ho	_		-		Ве	thes	sda]	Montgome	erv
	Funeral		5. Social Security Number	6 500	,	7. Age (In y	s. last birthday)	If Under		If Under	24 Hrs. Min.	8. Date of Bi (Month, D	irth		hplace (State or Foreign
	Director		323-18-637	3 1□	м 2ДF	93	Yrs.	Months	Days	Hours	MIII.	Sept	13,	1912	IL
	P .		Usual Residence of Deced			100	City, Town or Lo	antion							10d. Inside City Limits
	arylar show	_		County		100.	City, Town of Lc	cation							1 ☐ Yes ※XXNo
	8a-f	Director		ontgome	ery		Potomac	10f. Zip	Codo				10a Ci	tizen of What Co	nuntar?
	with the	급	10e. Street and Number 9910 River	ъч				101. Zip	208	25/			109.01	USA	,,
	e 234	Funeral	11. Marital Status		12 Was De	cedent Ever in	U.S. 13.	Was Deced			gin? (Spe	ecify Yes or N	0-	14. Race - Ame	erican Indian,
	item item	Į,	1 Never Married 2		Armed fi 1 ☐ Yes	Forces? 2 1X No		f Yes, spec	fy Cuba	n, Mexican	, Puerto	Rican, etc.)	!	Black, Whit	e, etc.
336	urs af		3 X Widowed 4 □ Di		If Yes, C Year or	Give		1 □ Yes 2	2X No	Specify:				Specify: Whi	te
ŏ	within 72 hours after death with the Maryland ane then "natural", or iteme 23e or 28e-f ehow he Medical Exercite from the Medical	Completed by	15. De	cedent's Edu	cation	-()	16a. Dece	dent's Usua kind of wor	l Occupa	ition	t of worki	na	16b. H	(ind of Business	Industry
215	a. en "r	ple	Elementary/Secondary ((1-4or 5+)	life.	DO NOT us	se retired,						
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nd	be filed value Hygia	Be	17. Father's Name (First, A								stina stina	e (First, Middle a Sulc		i Sumame)	
yla	Man Man Marke Marke	မ	Anton Fal				101 11 11		(0)					or Town, State, a	Zin Cada)
Maryland 21215-0036	12 sh and h and 7 ie m		19a, Informant's Name/Re												VA 20121
	l and taaltl		Valiant B I		Son	201	Place of Dispo cemetery, cree					Date		ocation - City or	
יסר	agas nt of nt of		1 ☐ Bunal 2 🖾 Crem	nation 3 🖾 F	Removal from	m State	cometery, crea LfeLegac			1	10-	21-05	Tuc	son, AZ	
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours aftar daath with tha Marylan Department of Health and Martal Hygiana Important: if Item 27 is marked other then "natural", or Items 23s or 28s-1 show amy injury or other traumatic event, the Wadical Exarctinat traus be notified at ance.		4 Donation 5 0	ther (Specify)	99			-							
Ba Ba	Depa impo eny i		K Grego	Y FIN		M01148						Glen Bu		e, MD 2	21061
		Н	23a. Part1. Enter the dise shock, ar heart failur	ase, or compl e. List only	cations that e cause or	t caused the de n each line.	eath. Do not enf	er the mod	e of dying	g, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		a	(000	restive	LH	en-	1	Fa	ilunc			dig
1	/Medical Examiner	Н	resulting in death)		Due t	o (or as a con	equence of):								
	- Xummer	_	Sequentially list conditions if any, leading to immedia	s, I	Due t	o (or as a cons	equence of):								
_	lad Insit	ulu	Cause (Disease or injury	ຶ ⊀	500 .	(
	ysician and is burial-transit	Examiner	that initiated events resulting in death) Last	•	Due t	o (or as a cons	equence of):								
760,	icata ba ey physician s tha buria	=		l.	d.				_						
89				=32											
Вох	death certifica	an/Med	IF FEMALE: 23b. Was decedent pregn	ant		outcome of predefined birth 2 F]€ctopic pr	egnancy					23d. Date of de	
B.	daati	SICIA	in the past 12 month 1 Yes 2 No	s?		gnant at time of		Other (sp						Month	Day Year
P.O.	that the de ad by the ded datached	Physici	9 Unknown									224 Did	400000		the cause of death?
	Se Ge	ā	Part II. Other significant of	onditions co	ntributing to	death but not	resulting in the u	nderlying c	ause give	en in Part I			Yes 2	. /	robably 4 Unknown
of Vital Records,	aquir aan si ould	eted										-			
ec	has b	ā										24a. Was	s an opsy formed?	24b. Were at prior to death?	utopsy findings available completion of cause of
E H		Compl										1 ☐ Yes	2 N		2 □ No
Z Z	Physician: The this cartificata al diractor, pag	_	25. Was case referred to examiner?		Hospital:	4	C15000		Othe	ar:		n (Check only		a Closh /a	- 1)
of		2	1 ☐ Yes 20 No 27. Magner of Death		28a. Dai	te of Injury	ER/Outpatier		28c. Injury Work			28d. Describe		6 ☐Other (Spe iry occurred	City)
O	Aftar funar	catlon		Pending investigation	(Mc	onth, Day Year) Injury	м		c? Yes 2∐	No				
Division	Attending r daath.	<u>≘</u>	3 ☐ Suicide 6 ☐	Could not be determined			t home, farm, st	reet, factor	y, office			28f. Location City or To			ural Route Number,
ă		Certifi	4 🗌 Homicide		Bui	ilding, etc. (Spe	жиу					Only of the	own, olai		
	Hospitel or the hours after Funeral Dir taly fillagd in	ical (29a. Certifier 1500	ertifying Phy	sician: To t	the best of my l	knowledge, deat	h occurred	at the tim	ne, date an	nd place,	and due to the	e cause(s	and manner as	s stated. e to the cause(s)
	_ (1 _ (8	Medi	one)			anner stated.	3,100								
	within To the	2	29b. Signature and title of	certifier						e number	10			ate signed (Moni	
	d in		1 PW			~	ν		V5	665	1		UCI	ober 2	0,7005
h '	1	4	30. Name and address of			_	_	Print)	w. 1	50.1	C	40		1 ach	0,2005
	-01	1	Matthew 31. Date filed (Month, Da)	(O ff		Megistaar's Si		0 /	-16-21	1 601	47	400	14_	P-0(" .	עושן ורווי
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						The second second	J-43 /14	Arms and the same	er						

DHMH 17 Rev 1/2001

ORIGINAL

RODNEY LOCKET

OCTOBER

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 3 121/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 4 2005 ORIGINAL

			For State Registrar		State of M	aryland / [Depa <i>Cer</i>	artment of H <i>tificate of I</i>	lealth an Death	d Mental		e2e005	34169
			Hegistrar Decedent's Name	First, Middle, La	st)					2. Date		g. 140.	3. Time of Death
-	Physici			WILSON L						OCTO		22, 2005	4:30 A. M
	/Medio Examin				e street and number)			4b. City, Town, or	Location of D			4c. County of Dea	
	Cxamiii	ici		DWICK RO				TOWSON	ī			BALTIMO	ORE
	Funeral		5. Social Security N	umber 6. S	ex 7. Ag	e (In yrs. last bii	rthday)	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date	of Birth	(ear) 9. Bi	rthplace (State or Foreign Country)
	Director		212-30-5	014	X□M 2□F	_73	Yrs.	Months Days	riouis	Hrs. 8. Date (Mont	7/19	32 NE	W YORK
	pu ,		Usual Residence of	Decedent 10b. County		10c. City, Tow	m or Lo	cation					10d. Inside City Limits
	anylai show	-	10a. State	,	7 E		WSOI						1 ☐ Yes 2 ☑ No
	8a-1	ectc	MD	BALTIMO	AL	10	WOOL				100	g. Citizen of What C	
	ath with the Marylan 23a or 28a-f show	ā	10e. Street and Nur	RDWICK R				10f. Zip Code 2128	26		100	USA	country :
	72 hours effer death with the Maryland natural', or Iteme 23a or 28a-f show dical Exertinetr met be motified at	Funeral Director		RDWICK R	12. Was Decedent	Ever in U.S.	13 \			(Specify Yes	or No-	14. Race - Am	erican Indian.
	after des or Items infiner in	'n	11. Marital Status 1 □ Never Marri	ed 2 X Married	Armed Forces?			Was Decedent of H f Yes, specify Cuba		uerto Rican, etc	2.)	Black, Wh	
38	al', or	by	3 Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:			Specify:	WHITE
21215-0036	72 hours "natural", polical Exp		/5	15. Decedent's E	ducation	16a	Deced	dent's Usual Occup	ation	working	16	6b. Kind of Busines	s/Industry
215	within 7 ene. than "n	pie	Elementary/Seco	, , , ,	College (1-4or	5+)	life. L	DO NOT use retired	t)	Working			T C C C C
21	filed wil Hygien other the	Completed			4+ YEARS		ENG_	INEER				ARTIN MAF	CLETTA
nd	should be filed withir nd Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Name									aiden Sumame)	
yla	should be to and Mental I marked o umatic eve	ဥ		JOSEPH L						BELLE			7-0-4-1
Maryland	12 sho h and 7 Is mu		19a. Informant's Na					HARDWICK				City or Town, State, 21286	21p (0000)
	s 1 and 2 should be filed within 72 hours after de I Health and Mental Hyglene. item 27 Is marked other than "natural", or Items other traumatic event, the Medical Exertinet:		20a, Method of Disp	OCHTE/WI	· ·	20b. Place o	of Dispo	sition (Name of		TOWSON Date		Oc. Location - City o	r Town, State
ģ	ages nt of t: If it		1 🖾 Burial 2	☐ Cremation 3 ☐	Removal from State	DULAN	ery, cren EY_1	natory or other place VALLEY ME	:e) М. 10	0/25/20	05	COCKEYSVI	I.I.F MD
Baltimore,	artme ortani Injury		21. Signature of Fu	5 Other (Special		G.							HOME, P.A.
Ba	permit. Pages 1 am Department of Heali Important: If item 2 any Injury or other once.		Hea	The H	Harl	/		8 521 LOCH					1286
			23a. Part I. Enter the hock, or hea	he disease, or com rt failure. List only	plications that cause ope cause on each li	the death. Do	not ent	er the mode of dyin	g, such as car	diac or respirat	ory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (netas	fatic 1	2005	tate Can	cer				Mon745
	/Medical Examiner		resulting in death)	(w	a consequence						_	
	LAGITITIE	_	Sequentially list co	nditions,	b		-6):	· · · · · · · · · · · · · · · · · · ·					
	ed sit	Examiner	Sequentially list confirmed any, leading to imcause. Enter Under Cause (Disease or	nmediate orlying injury	Due to (or as	a consequence	oi).						
_	xecut and Il-trar	xan	that initiated events resulting in death)		C. Due to (or as	a consequence	of):						
68760,	The law requires that the death certificate be executed the as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ai			-								
687	ficate physics the	edicai			d								
Box	leath certifi attending for use as		IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome			le				23d. Date of de	elivery
B.	death e atte d for	Physician/M	in the past 12	months?	4□Pregnant a	2 Fetal death t time of death]Ectopic pregnancy] Other (specify)	1		_	Month	Day Year
P.0	that the de ted by the a	hys	9 🗆 Unknown		9□ Unknown								
	res tha igned l	by P	Part II. Other signif	ficant conditions	contributing to death b	ut not resulting i	in the ur	nderlying cause giv	en in Part I.	23e.			to the cause of death?
rd	w require been si									_	1 🗌 Yes	2 No 3 F	Probably 4 Onknown
ec C	e law r has be je 2 sh	Completed								_	Was an autopsy	prior to	utopsy findings available completion of cause of
H.		Son								101	performe 'es 2 5	ed? death? No 1 ☐ Ye	
of Vital Records,	Physician: The tribic tribic tribic certificate har all director, page	Be	25. Was case refer examiner?	red to medical	Hamitali			Oth		Death (Check	nly one)		
of \	E = -	၉	1 Yes 2 2		Hospital: 1 Inpati		utpatien Time of		4 11111511			ce 6 Other (Speringury occurred	ecify)
	ding Ph th. After th funeral	lon	1. Natural	5 Pending	(Month, Da		Injury	Wor	yai k? Yes 2 □ No	200. Desc	IDE NOW	injuly occurred	
18	death death stor:	lcat	2 ☐ Accident 3 ☐ Suicide	investigatio	e 200 Place of In	jury - At home fa	arm str	eet, factory, office		28f. Locat	ion (Stre	et and Number or F	Rural Route Number,
Division	after Direction by	Certification:	4 Homicide	determined	building, e	c. (Specify)					r Town,		
_	spita hours neral / fillec	ai C	29a. Certifier	1. Certifying Pt	nysician: To the best	of my knowledg	e, death	occurred at the tir	ne, date and pl	lace, and due to	the cau	ise(s) and manner a	s stated.
	To the Hospital or Attending Pi within 24 hours after death. Of the Funeral Director: After the completely filled in by the funera	edical	(Check only one)	2∐ Medicel Exa	miner: On the basis of and manner st	r examination ar ated.	na/or in			occurred at the			
		×	29b. Signature and	- 1	1			29c. Licens				d. Date signed (Mon	
)	1		for	on Blee	& MD			000	61199		De	cr, 24, 2	001
1)) '			ress of person who	completed cause of	death (Item 23a)	(Type,	Print)	22 7			112011	
0	L-		Jason	Wh Day Yours	5565 Novi	4 Charle	5 57	, suite to	03,100	nsone	N	21209	
	Sta Registi		31. Date filed (Mon	CT 2. 1 2	32. Fe gisti	ar a dignature		carel					
	ricgisti	-		/U N 3E -	1000		0						

		_	For State Registrar	State of Maryla		artment of Hertificate of L			iene 005	34170
			Decedent's Name (First, Middle, La	st)				2. Date of Deat	th Day Ye	3. Time of Death
	Physici /Medio		LORRAINE	LORDEN				Oct-	20, 200	- 200 CLW
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or			4c. County of D	eath
1			Mercy Medical	Center		Baltin			NA	
	Funeral		Social Security Number 6. S	Cu offe	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		215-30-2648	UM 2⊠F 71	Yrs.			Dec. 1	8,1933 N	Maryland
	and w		Usuel Residence of Decedent 10a, State 10b, County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	/anyl	ō	W - 1 - 1	,		D -	. 3 - 1			1 ☐ Yes 2 ☑ No
	289-	Director	Maryland Bal 10e. Street and Number	timore		10f. Zip Code	edale	1	0g. Citizen of What	Country?
	death with the Maryland ms 23s or 28e-f show Linust Le inclined at		6 Bantry Court			21237			United St	ates
	Jeath ms 2:	Funerai	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp		14. Race - A	merican Indian,
9		Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				Rican, etc.)		/hite, etc.
ğ	hours after tural', or Its	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2% No	Specify:		Specify:	White
21215-0036	72 hours "natural", ideal Exe	Completed	15. Decedent's E	ducation ade completed)	(Give	ient's Usual Occupa kind of work done di	uring most of work	ing	16b. Kind of Busine	ss/Industry
2	within ene. then "	효	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)				
2	filed withir If Hygiene. other then		12 Years		Mail	Room Cle		e (First, Middle, M		ce Company
Maryland	s 1 and 2 should be filed within 72 hd I Health and Mental Hygiene. Item 27 Is marked other than "natur other treumatic event, the Medical	Be	17. Father's Name (First, Middle, Last, John Lorden					Ehmke	naiden Sumame)	
3	2 should be a name of the state	٩		Time Print)	10h Mailie	g Address (Street a			City or Town State	a Zin Code)
Mai	12 st h and 7 Is n treun		19a. Informant's Name/Relationship (Ms Shirley Lorde:		1	antry Cou				1237
	s 1 end 2 of Health item 27 I		20a. Method of Disposition		D. Place of Dispo	sition (Name of		-	20c. Location - City	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ott		1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory or other place				
Ē	ft. Partitions		* 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer			n Cemeter	The second second	2005	Baltimor	e, Maryland
Ba	perm Depa Impo any i		21. Signature of Political Service Lice	Managal	D	uda-Ruck I	Funeral 1			Inc.
			23a Part Enter the disease, or com	plications that caused the d	eath. Do not ent	922 Wise 2 er the mode of dvind	Ave. Dui	ndalk, Ma	aryland —	21 222 Approximate
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	Machine I.			, 000		,	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a Bladder		er				
1	Examiner			Due to (or as a cons	sequence or):					
		- G	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of):					
	uted I Insit	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							2
	certificate be executed nding physicien and use as the burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a cons	sequence of):					
8760,	e be rsicie	dicail		d						
9	ifficat g phy as th	edi						=85377=55		
Box	~ = -	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-		Ectopic pregnancy			23d. Date of	
	0 0 0	icia	in the past 12 months? 1 □ Yes 2 Mo	4□Pregnant at time of		Other (specify)			Month	Day Year
P.O.	the ache	hys	9 Unknown	9 Onknown						
	w requires that i s been signed by should be deta	by F	Part II. Other significant conditions of	contributing to death but not t	resulting in the ui	nderlying cause give	n in Part I.			to the cause of death?
pic	requires een sign nould be	ed						1 ☐ Ye	s 2 □ No 3 □	Probably 4 Dunknown
Division of Vital Records,	law re as be	Completed						24a. Was ar autopsy	24b. Were	autopsy findings available to completion of cause of
m.	The ate has page	E						perform 1 ☐ Yes	yed? death	? es 2□ No
ita	stiffica ctor,	Be	25. Was case referred to medical examiner?					h (Check only one	9)	
>	Physicien: rthis certific ral director,	٥	1 ☐ Yes 2 No		☐ ER/Outpatien		4 Nutsing Ho	me 5 🗆 Reside	nce 6 Other (S	pecify)
0	ng Pi		27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 ☐ Accident investigation				es 2 □No			
Ξ	or Att	Certification;	3 Suicide 6 Could not b 4 Homicide determined		t home, farm, str ecify)	eet, factory, office		City or Town		Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 s		ha ha war an				- Los L 15			
	Hospitel Pours S Funerel	Medicai		iysicien: To the best of my k niner: On the basis of exam and manner stated.						
	To the within 2 To the complet	Med	29b Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (Mo	onth, Day, Year)
	2 × ≥ 2 8		S	2					ml 25	2005
	. «		Omer	complaind arrive of death (tem 22a\ /T		e78	(LT 20	2005
	10,		30. Name and address of person who			A .	Un aid	201		
	,	10	31. Date filed (Month, Day, Year)	301 St Paul	Street	DETERMINE	MD 217	01		
	Sta Registr		OCT 2 4 200	56	1. Some	20				
			J J	JANES SON	19	/				

SHERRY LYNN LEVIN

		1 - For Registrar 1. Decedent's Name (First, Middle, Las	et)		artment of Health and rtificate of Death	Reg	. No.	3. Time of Death
Physic /Medi		Sherry Lynn					Oay 2005	8:36 p M
Exami		4a. Facility Name (If not institution, give Carroll Hospital			4b. City, Town, or Location of Dea Westminster	th	4c. County of Death Carroll	
Funeral Director			ex □M 2☐F 4	e (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birth Cou 1965 Mary	place (State or Foreign Try) Land
yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits
he Mar 28a-1 el	Director	Maryland Carrol 10e. Street and Number	1	Westmi	nster 10f. Zip Code	100	. Citizen of What Cou	1 ☐ Yes 2 ☐ No
h with 1	ai Dir	3930 Old Hanover	Rd.		21158	109	U.S.A.	My.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be rotified at any injury or other traumatic event, the Medical Examinat must be rotified at any organ.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	10	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes ②☐(No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
Dermit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or any injury or other traumatic event, the Medical Evant party injury or other traumatic event, the Medical Evant Dates.	mpieted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of wi DO NOT use retired) ht Master	orking	b. Kind of Business/In	dustry Government
e filed value other to	Be Co	17. Father's Name (First, Middle, Last)		11000	18. Mother's Na	me (First, Middle, Ma	iden Sumame)	0000111110110
d Menta	To	Louis Michael Bro		10b Mailie	Shirle	y Naomi En		Code
alth and 2 shalth and 27 is r		Harris J. Levin -			Old Hanover Rd.			
ges 1 a t of Hea If Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory`or other place)		c. Location - City or Te	
nit. Pa artmen ortant: injury		* 4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			n Cem. Oct. 24,20 2 Name and Address of Facility Ckpardt runeral		arkton, Md	•
permi Departiment Importanting		23a. Part1. Enter the disease, or com	ka .	12	290 Charmil Dr.	hapel P.A lanchester		2
ifficate be executed W/ ifficate be executed was the burial-transit as the burial-transit	licai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a eud Due to (or as b Due to (or as		cerdial info	cretion		Inierval Between Onset and Death
that the death certificate ed by the attending physidetached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
w requires s been sign should be	Completed by P	Part II. Other significant conditions of	contributing to death b		nderlying cause given in Part I. Hterine cerv	1 ☐ Yes 24a. Was an autopsy performs	prior to co	
Physician: The la r this certificate has	Be	25. Was case referred to medical examiner?	Hospital:	- Andrew	Other	eath (Check only one)	. 50	
Attending Physic death. ector: After this by the funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		it 3 DOA 4 Nuising	28d. Describe how	ce 6 □Other (Special injury occurred	y)
al or Atte safter de I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
pita urs ara	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best miner: On the basis o and manner sta	examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the cau surred at the time, date	se(s) and manner as s and place, and due t	tated. o the cause(s)
n 24 ho he Fun		29b. Signature and title of certifier	1 .		29c. License number	29d	l. Date signed (Month,	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	M	> Hounds	Javort	m.D.	7.0	3 4	10/26/	c J ~
To the Hos	M	30. Name and address of person who	completed cause of a	eath (Item 23a) (Type,	Print)			

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

MCDANIELS

			For State Registrar	State	of Marylan	d / Depa <i>Cer</i>	rtment of H	ealth and M Death	Reg	e2e005	34173	
	Physicia		Decedent's Name (First, Middle Ouida	e, Last)		McC	ormick		2. Date of Death Month 10 20	Day 2005	3. Time of Death 9:35a M	
	/Medic Examin		4a. Facility Name (If not institution Joseph Richy		umber)			Location of Death		4c. County of Death NA		
	Funeral Director		5. Social Security Number 217–68–2258	6. Sex 1 ☐ M 2 ☐ ▼F	7. Age (In yrs. 47	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 12–1–5	Year) 9. Birth	hplace (State or Foreign huntry) Md.	
	D	tor	Usual Residence of Decedent 10a. State 10b. County Md. Balti		10c. Cit	y, Town or Lo					10d. Inside City Limits 1√2 Yes 2 □ No	
1	with the g or 28e	Director	10e. Street and Number		7n+ 3(10f. Zip Code 21093		10	g. Citizen of What Co USA	untry?	
36	be filed within 72 hours after death with the Maryland ital hygiene. id other than "efurel", or items 23s or 28e-f show event. Its Mcdral Exam her miss be notified at	by Funeral	2402 Chetwood 11. Marital Status 1 Never Married	12. Was Der Armed F ried 1 □ Yes If Yes. G	cedent Ever in U Forces? 2 1 No Sive X	.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race · Ame Black, White		
21215-0036	within 72 hour ene. than "neturel'	Completed b	15. Deceder (Specify only highe Elementary/Secondary (0·12)	nt's Education st grade completed		(Give life. L	tent's Usual Occupa kind of work done of DO NOT use retired	furing most of work ')	ing	6b. Kind of Business/		
	ould be filed w Mental Hygie varked other ti	Be Co	12th grade 17. Father's Name (First, Middle,	Last)			inistrati	18. Mother's Name	e (First, Middle, M	aiden Sumame)		
aryland	should be filed nd Mental Hygi marked other umatic event.	To	Floyd 19a. Informant's Name/Relations	ship (Type, Print)	5	Stovall 19b. Mailin			abeth al Route Number,	Holema City or Town, State, 2		
altimore, Ma	1 and 2 : Health ar tem 27 is		Jed McCormick 20a. Method of Disposition 1 \Rule Burial 2 \(\times \) Cremation	3 □Removal from	n State	cemetery, cren	natory or other plac	θ)		Timonium Oc. Location - City or	Bernald Control	
Baltin	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Fundal Service	Licensee		22	Hill Cem. Name and Addres March F.H	ss of Facility East	Balti 1101 E	more, Md. . North Av		
į	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	caused the deal	NOM	er the mode of dyin	g, such as cardiac	or respiratory arres	mets	Approximate Interval Between Onser and Death	
,0,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	o (or as a consec					1		
. Box 68760,	death certificate b ie attending physic ed for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in U Past 12 months? 1 □ Ves 2 □ No	1 ☐ Live	outcome of pregni	aldeath 3□	Ectopic pregnancy			23d. Date of del Month	ivery Day Year	
ds, P.O.	ires that the de signed by the a d be detached f	by	9 ☐ Unknown Part II. Other significant conditi			sulting in the u	nderlying cause giv	en in Part I.		acco use contribute to 2 ☑ No 3 ☐ Pr	the cause of death?	
Record	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed							24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of	
Vital	certifica rector, p	o Be C	25. Was case referred to nedical examiner?	Hospital	☐Inpatient 2☐]ER/Outpatien	oth Oth	00	h (Check only one		Hamas	
Division of	tending leath. tor: After the fune	Certification: To	3 Suicide 6 Could	ng 28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time of Injury	f 28c. Injun Worl		28d. Describe how		Mayres	
Δį	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifyi	ng Physicien: To the	lding, etc. (Speci	owledge, death	n occurred at the tin		and due to the cau	State) use(s) and manner as	stated.	
	To the Howithin 24 To the Fi	Medical	(Check only 2 Medical one) 29b. Signature and title of certifications	and ma	anner stated.	2	29c. Licens			d. Date signed (Monta	1	
(N		30. Name and address of person	who cometed ca	lyse of death (Ite	/23a) Type,	Print	M Bil	HMOU	d Bal.	2/218	
1	Sta Regist		31. Date filed (Month, Day Kear	4 2005	. Aggistrar's Sign	ature	perte	y Juli	11.11616	11111	1	

Please Type or	Print in Black I	Indelible Ink.	Ensure A	II Copies	Are Legible	∍.
State of	of Maryland / De	partment of H	lealth and I	Mental Hyg	iene 005	5

			For State Registrar	State of M	laryland / Depa <i>Cer</i>	artment of F	lealth and M Death	Reg	eng 005	34174
	Physicia	an	1. Decedent's Name (First, Middle, Las	unhorin	j			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give	_)		r Location of Death		4c. County of Death	0.30
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last birthday) 7 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Cou	place (Stete or Foreign ntry) SOURİ
	Aaryland f show	o	Usual Residence of Decedent 10a. State 10b. County Maryland		10c. City, Town or Lo					10d. Inside City Limits Yes 2 □ No
	with the N 3e or 28e- It be notifi	Funeral Director	10e. Street and Number 4300 E. Lombard S	treet Apt		10f. Zip Code	1224	10g	. Citizen of What Cou USA	
36	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Medical Eraciliwit cast be mullised at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced	12. Was Decedent Agned Forces 14 Yes 2 ☐ If Yes, Give Year or Dates:	No	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2☐No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
21215-0036	within 72 hou ane. then "nature	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or	16a. Deced (Give life. I	lent's Usual Occup kind of work done DO NOT use retired	ation during most of word d) :	king	Bb. Kind of Business/Ir	,
Maryland 2	uld be filed Aental Hygie rked other tic event, L	To Be Co	17. Father's Name (First, Middle, Last) Clarence Mahurin				Sylvia	e (First, Middle, Ma Sulliva	niden Sumame) N	
	and 2 sho salth and N n 27 is ma			Type, Print) ughter)	4300	E. Lombaı	d Street	Apt #1 B	city or Town, State, Zi altimore M	id 21224
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23e or 28e-f show any injury or other treumatic event, the Pedical Exercitival relative and once.		20a. Method of Disposition 1 □ Burial 2√ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2) 21. Signature of Funeral Service Licer		1 22	rematory . Name and Addre	Inc 10/2	2/2005 B uzdzinski	altimore M Funeral H ex, Maryla	aryland Iome PA
760,	/Medical Examiner and parial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter theyling Cause (Disease of injury that initiated events resulting in death) Last	b	s a consequence of): s a consequence of): s a consequence of):	nlumon	(0			Onset and Death
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of delive	ery Day Year
Δ.	quires that in signed by uld be deta	ed by Ph	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	<u></u>	cco use contribute to	_
Il Records,		Completed	Sp cerepturase	war ac	redent			24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 2 ER/Outpatien	t 3 DOA Oth	15 TO SEC. 12 (ST. 1)	th <i>(Check only one)</i> ome 5 ☐ Residen	ce 6 ☐Other (Speci	(y)
Division of	Attending Phyrdeath. ector: After thi	Certification; T	27. Manner of Jeath 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		ay Year) 28b. Time of Injury At home, farm, str	M 1 □	yat k? Yes 2⊡No		et and Number or Rur	al Route Number,
Div	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	cal Certif		building, e	etc. (Specify) It of my knowledge, deatled of examination and/or in-	n occurred at the til			se(s) and manner as	
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner s	stated.				I. Date signed (Month,	
	14/		30. Name and address of person year	completed cause of	death (Item 23a) (Type,	Print) ampheli	e Blad	Balto,	AD 212	36
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 4	32. Regis	trar's Signature	osile		• •	,	

			For State Registrar	State of M	laryland / Depa	artment of H	lealth and M Death	lental Hygie		34175
T.	Physicia /Medic		1. Decedent's Name (First, Middle,	MC GILL				2. Date of Death Month	Daylh Year	3. Time of Death
)	Examin	er	4a. Facility Name (If not institution,	-	r)		Location of Death		4c. County of Death Baltimo	
			Northwest Ho		ige (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Funeral Director		215-46-7010	X XM 2□F	60 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ear) Co	hplace (State or Foreign untry) MD
	and w	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			7	10d. Inside City Limits
	Many 1 sho	ō	MD Balt	imore	Caton	sville				1 ☐ Yes 2 ☐ No
	r 28e	Funeral Director	10e. Street and Number	1	0.00.	10f. Zip Code		10g	. Citizen of What Co	untry?
	h with	OF	6902 Upper Mi	lls Circl	e	2]	L228		U.S.A.	
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
98	or its		1 Never Married 2 Marrie	ed 1v Yes 2 If Yes, Give]No	1 ☐ Yes 🛂 No	Specify:		0 "	
8	72 hours after death with the Maryland neturel', or teme 23a or 28e-1 show dical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates	·		ation	100	E	Black
7		Completed	15. Decedent' (Specify only highest	grade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work	ing	b. Kind of Business/	moustry
12	filed within Hygiene. kther than *	mo	Elementary/Secondary (0-12) 12th grade	College (1-40)		l Estate	Specia	lict	Verizon	,
b	e filed within al Hygiene. i other than ' vent, ine Ma	BeC	17. Father's Name (First, Middle, L		, itea	I DCCCC		e (First, Middle, Mai		
lan	should be and Mental I e marked o	To B	Albert McGil	1		t	Villie M	lae Brow	n	
Maryland 21215-0036	shor and N e mai		19a. Informant's Name/Relationsh	ip (Type, Print)					*	Tip Code) 21228
	and 2 palth a 27 I er tra		Augustine McG	ill-Wife			Mills Ci	rcle, C	atonsvil	le, Md
ore	of He fiten r oth		20a. Method of Disposition ↓□ Burial 2 □ Cremation	3 □ Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	e) [Date 200	c. Location - City or	Town, State
Ĕ	Peg ment ant: I ury o		4 Donation 5 □ Other (Sp		Arbutus			2/05 A	rbutus,	Mď
Baltimore,	permit. Pegas 1 and 2 should be Department of Health and Menta Important: If item 27 le marked any injury or other traumatic et once.		21. Signature of Funeral Service L	b. Ke	le M 4	Name and Address arch F/F 300 Waba	s of Facility I West ash Ave,	Baltim	ore, Md	21215
г			23a. Par 1. Enter the disease, or o shock, or heart failure. List of	complications that cause only one cause on each	ed the death. Do not ent line.	er the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	a METHST	ATIC HEN	SMALL CE	4 Lung	CANCE	ER.	Onset and Deam
	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of):	222	4	= 1,140,16 1,140,00		
		_	Sequentially list conditions,	b. — Due to for a	is a consequence of).	TOPEMIA.				
Т	tad nsit	nlu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	330 15 (51.5	, , ,					
	ai-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a consequence of):					
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	call		d						
9	tificat ng phy as th	ed .		1						
Вох	leath certifi attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth		Ectopic pregnancy			23d. Date of deli	
		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant : 9□Unknown	at time of death 5	Other (specify)			Month	Day Year
P.0	d by t	Phy	9 Unknown Part II. Other significant condition	as contributing to death	but not regulting in the u	ndorhring payes ave	on in Bort I	23a Did tahan	co use contribute to	the cause of death?
ŝ	law requires that the de as baan signed by the a 2 should be detached f	by	Part II, Other significant condition	is contributing to death	but not resulting in the u	ndenying cause give	on meant.	1 ☐ Yes		
Records,	w require baan sig should b	Completed						-		
3ec	9 4 6	mpl						24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
	ilcian: The l certificata ha rector, page		22 M					1 Yes 2 €		200 No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🔀 Inpat	tient 2 ☐ ER/Outpatier	at 3□ DOA Othe	200	n (Check only one)	e 6 Other (Spec	
o	Phys or this oral di	-4	27. Manner of Death	28a. Date of In	jury 28b. Time o	_		28d. Describe how i		ny)
on	th. : After s tuner	tlo	1 Natural 5 Pending 2 Accident investigs		ay Year) Injury		Yes 2 No			
Division	i Site	Certification:	3 Suicide 6 Could not determine	280. Place of I	njury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ruitate)	ral Route Number,
_	Hospitel				at of my knowledge, death					
	To the H within 24 To the F complete	ledical	one)	and manner s	stated.					
	To the within To the comple	Σ	29b. Signature and title of certifier	m-ella n	2	29c. License	H10		Taber 18	Luay, rear)
! ,	N 15		Jog Inda						rance 18	1 4000.
			30. Name and ad less of person w	^			DE MI		0.0	
*	- W			- II 5 A P				0 ()		
7	51 , 1		31 Date filed (Month Day Year)	32 Regis		MADRUS	TOWN M	10 21	1.22.	
100	Sta Registr	_	31 Date filed (Month Day Year)	32. Regis	LENTER R strar's Signature		TOWN W	10 21	1.2.5.	

			- FOI	eartment of Health and Menta ertificate of Death	l Hygien Reg. N	711115	34176
	Dhusisi		1. Decedent's Name (First, Middle, Last)	Mo	e of Death	ay Year	3. Time of Death
	Physici /Medic		James E. McGee			6 2005	8:05 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 8487 Bussenius Road	4b. City, Town, or Location of Death Pasadena	4	c. County of Dea Anne A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dat	e of Birth onth, Day, Year		thplace (State or Foreign
	Director		214-14-3047 1XM 2 F 84 Yrs.	Months Days Hours Min. (Mo	14	1921	MD
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary	tor	Maryland Anne Arundel	Pasadena			1 ☐ Yes 2 🔯 No
	or 28g	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Co	ountry?
	ath wi	rai	8487 Bussenius Road	21122		USA	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, Ite Modical Exacting front the notified an once.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	72 ho	Completed	(Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working	16b.	Kind of Business	Industry
121	within ne.	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	Plant Worker	Ca	lvort D	istillery
	filed v Hygie other t	е Со	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,			istillery
an	should be and Mental a marked o umatic eve	To Be	James G. McGee	Evelyn K	. Ger	big	
Baltimore, Maryland	and 2 shores alth and N n 27 is mare traumare.			ling Address <i>(Street and Number or Rural Route</i> 37 Bussenius Road, Pas			
ore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	ematory or other place) UCL. 18		ocation - City or	
Ĕ	t. Pages rtment of h rtant: If ite		'4 □Donation 5 □Other (Specify) Metro Cr	ematory Inc. 2005	-		Maryland
Ba	permit. Departm Importa any inju	_	Muschell Stations	3111 Mountain Road,	Pasade	uneral l	
			23a. Part Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line	. 0 1			Approximate Intervat Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	stack (4) many	Vissu	↓	
	Examiner						
	pd jig	iner	Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	xecute and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				_
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicalE	d				
9	ntificat ng phy as th	ledi	IESEMALE.				
Вох	death certifica attending ph d for use as th	Physician/Me		□Ectopic pregnancy		23d. Date of del Month	ivery Day Year
	that the de ed by the a detached f	ysic	1	Other (specify)			
, P.O	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	e. Did tobacco	use contribute to	the cause of death?
rds	w require been sig should b	ed b	Cardienogofoly		1 Yes 2	!□No 3□Pr	obably 4 Unknown
ecc	has be	Completed by		246	a. Was an autopsy	prior to d	topsy findings available completion of cause of
Vital Records,	Th ate pag				performed? Yes 22 N	death? 1 ☐ Yes	21 No
	siciar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Checker) ont 3 DOA Other: 4 Nursing Home 5		6 □Other (Spec	cifu)
0	ding Phys h. After this funeral di	-	27. Manner of Death 28a. Date of Injury 28b. Time of Manner of Death		scribe how inju		31))
Sior	Attending Physician: sr death. ector: After this certific. by the funeral director.	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	(2)		
Division of	l or Attencatter death Director:	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		or Town, Stat		ral Route Number,
	ospital hours uneral ly filled	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	To the H within 24 To the Fi complete	Med	29b. Signature and title of Contifier	29c. License number		ate signed (Montl	
)	. 1		Minhor	1231551	Oc	teber 1	1,2005
6	1	(90. Name and address of person who completed cause of death (Item 23a) (Type	Print DING Flan B	لامن ور	W- 21	06)
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 2005	really i			
	1091011		UUIN & LUUU TORISED AT ME				

		-	State of Maryland / Department of Health and Me 1- For State Registrar Certificate of Death	ental Hygief	
	Physici		A A A A A A A A A A A A A A A A A A A		year Year 1840 P M
	/Medic Examin	al	Ma. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	OCF 15	c. County of Death
	Examili		University of maryland medical Conter Bultimore		NIA
	Funeral Director			B. Date of Birth (Month, Day, Yea AUG 29 15	9. Birthplace (State or Foreign Country)
	fand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e-f sh	ctor	PA Luzerne Wilkes-Barre		1 ☐ Yes 2 🗹 No
	th with the 23e or 28	Funeral Director	100. Street and Number 195 River Street 18704	10g. (Citizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "naturel; or Items 23e or 28e-f show other treumetic event, the Madical Examination and the rolling at	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give 1 Widowed 4 Movorced 12. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
215-0036	1 and 2 should be filed within 72 hours Health and Mental Hygiene. Iom 27 Is marked other than "naturel", ther treumetic event, I'va Medical Exa	Completed I		9	Kind of Business/Industry Nikes-Barce Truck
and 2121	be filed winter Hygien of other the event, the	Be	17. Father's Name (First, Middle, Last)	First, Middle, Maide	en Sumame)
Maryland	should I nd Meni marke umetic	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural I		
	and 2 salth ar 27 is er treu		MARK M. McKeown II 48 Pierce Street Apt		
3altimore,	Pages 1:		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) 3 Removal from State		Location - City or Town, State Altimore MD
Balti	permit. Pages Department of Importent: If II any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Addres of Facility FINK FUNERAL HOME P.S. MOLITE 426 CRAIN HOW SW	A. Burni	e. Md 21061
	*. <i>gi</i>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease of condition resulting in alth)		Olise(and Death
	/Medical Examiner		Alanda de consequence on.		
	T. T	ner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury). Due to (or as a consequence of):		
	certificate be executed Iding physician and Ise as the burial-transi	Examiner	Cause (Disease or injury that initiated events c		_
8760,	sician buria	SalE			
9	rtificate ng phy as the	Jedic	IS FEMALE.		y and the second
O. Box	death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year
ت ،	requires that the de een signed by the tould be detached	by	Part II. Other significant conditions continuously to could but not recoming in the articolying cause growth artic		o use contribute to the cause of death?
Division of Vital Records,	The law ate has by page 2 sh	Completed		24a. Was an autopsy performed 1 Yes 241	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		
of	Phys this ral di	To To	1 Yes 2 No 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hom	e 5 Residence 3d. Describe how in	6 ☐Other (Specify) jury occurred
ion	Attending I r death. ector: After by the funer	atlor	1. ANatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
Divis	el or Atte s after de il Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	edical (29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and place, and manner stated.		
	To th withir To th	M	29b. Signature and title of certifier 29c. License number	29d. [Date signed (Month, Day, Year)
	X		1)- 1 Dam AU4176435 DIS 818	00	+ 15,2005
1	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nore mi	0 21236
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Regist	rar	OCT 2 4 2005 James & James		

		1	For State Registrar	State	of Maryland		rtment of H		nd Mental Hy	giene Reg. No.	2005	34178
魏	Physicia	ın	Decedent's Name (First, Middle	, Last)		m	rsh		2. Date of Do Month PC 10De	Day	9. 2000	3. Time of Death 5 03.11 PM
	/Medic Examin		la. Facility Name (If not institution	, give street and nu	ımber)	7.16	4b. City, Town, or	Location o			County of Death	1
			The Johns Ho	PKINS 1	HOSPI1	tal	Baltim	ore.	City		N/A	
- 8	Funeral Director		332 - 26-5434	6. Sex	7. Age (In yrs. I	V	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Sate of Bi (Month, D		Cor	nplace (State or Foreign untry) NOIS
	and *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	within 72 hours after death with the Maryland one. Than "naturel", or items 23a or 28e-f ehow he Medical Exercitat must be notified at		Arkansas Bax	ter		Mounta	inhome					1 ☐ Yes 2 ☐ No
	7.28e	<u> </u>	10e. Street and Number				10f. Zip Code		i i	10g. Citi	zen of What Co	untry?
	23a o	a D	319 Kingsberry	Drive			7265				S.A.	
	- ms	Iner	11. Marital Status	12. Was De Armed F	cedent Ever in U. orces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig n, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0-	 14. Race - Amer Black, White 	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Tyes If Yes, G Year or	2 No hive X	İ	1 ☐ Yes 2 ☒ No	Specify:			Specify: Wh	ite
215-0036	hour ture!	ed b	15. Deceden		Dates.	16a. Dece	dent's Usual Occupa	ation		16b. Kii	nd of Business/l	
15	n na	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)		kind of work done of DO NOT use retired		of working			
212	filed with Hygiene Ither thai	E	8	College	(1-401 3+)	Superv	isory Inspe				orolla	
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heath and Mental hygiene. I then 27 is marked other than "naturel", or items 28a or 28e-f ehow then 27 is marked other than "naturel", or items 28a or 28e-f ehow other traumatic event, the Medical Exercitation into the notified at	Be	17. Father's Name (First, Middle, Ray Walker	Last)					i's Name <i>(First, Middle</i> ie Peterson	e, Maiden	Sumame)	
Maryland	sould be 3 Mental narked o	To	Ray Walker 19a. Informant's Name/Relations	hin (Tuna Print)		19h Mailie	ng Address (Street		or or Rural Route Numi	her City o	r Town State 2	Tin Code)
Z Z	nd 2 sho lth and 27 is my traum		Sharon Munkvold -						ountainhome,			,,
-	s 1 and 2 if Health item 27	-	20a. Method of Disposition		20b. P		sition (Name of matory or other place		Date	, , , , , , , , , , , , , , , , , , , ,	ocation - City or	Town, State
OF.	ages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation	3 □Removal from pecify)	n State		rvice Corp.	!	0/24/05	Ta	wson, Mar	vland
Baltimore	permit. Page Department o Importent: If Imy injury or	1	21. Signature of Funeral Service		her Cain		2. Name and Addres					y ICHAI
ň	Depa Depa Impo		1 Cea	Ihar (den	5	305 Harford	Road	Baltimore, Ma	ryland	•	
*	Physician /Medical Examiner		23a, Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	caused the death each line.	Show	ek			arrest,		Approximate Interval Between Onset and Death 7 DAVS
3760, <	ite be executed sysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S	o (or as a conseq	uence of):	inal_	sep	515			ryays
ж 68	ertifica sing pt e as t	Med	IF FEMALE:	220 If you	outcome of pregna	3004					22d Data of dal	
P.O. Box	that the daath certificat ed by tha attending phy detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	e birth 2 ☐ Feta gnant at time of d	Ideath 3[Ectopic pregnancy Other (specify)	<i>'</i>			23d. Date of del Month	Day Year
	uires that signed b Id be deta		Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	inderlying cause giv	en in Part I	`	tobacco u Yes 2		the cause of death?
Vital Records,	sician: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed							24a. We aut per	opsy formed?	prior to death?	itopsy findings available completion of cause of
ita	ian: artifica ctor, p	Bec	25. Was case referred to medica examiner?	4					of Death Check only	оле)		
>	hysic this ce al dire	Tol	1 ☐ Yes 2 📉 No			ER/Outpatie		4 INL	ursing Home 5 Re			cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pendi	19	te of Injury onth, Day Year)	28b. Time of Injury	Wor	yat rk? ∣Yes 2. []	28d. Describe	now injui	ry occurred	
Division of	or Attending Physician: ter daath. irector: After this certific h by the funeral director,	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deter	ninod 289, Pla	ice of Injury - At h Ilding, etc. (Specia	ome, farm, st	reet, factory, office	165 2	28f. Location	(Street an		ural Route Number,
٥	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier (Check only one)	Examiner: On the	the best of my kno basis of examina anner stated.	owledge, dea ation and/or in	th occurred at the til	me, date ar opinion, dea	nd place, and due to the	e cause(s) e, date and) and manner as d place, and due	s stated. to the cause(s)
	within 2 To the	Med	29b. Signature and title of certific				29c. Licens				te signed (Mont	
	F 5 F 0) YA				Re	5-1	200	Oct	ober 2	2, 2005
	6		30. Name and address of person	who completed ca	ause of death (Iter	m 23a) (Type	Print) VolFE St	4 B	000 altimol	e,	MD	21287
		ate	81. Date filed (Month, Day, Year) 32	Registrar's Sign	ature				/		
1-	Regist	rar	OCT 2 4	2005	Miles &	The Age	NE)					

		•	For State of Maryland / State of Maryland / Registrer	Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 5 3 4 1 7 9	
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 2. Date of Death Month Day Year 2. Date of Death Apolth Day Year 2. Date of Death	M
	Examin Funeral Director	Ğ.	4a. Facility Name (If not institution, give street and number) 5. Social Security Number 215-69-4472 Age (Infyrs. last in the second street and number) 7. Age (Infyrs. last in the second street and number)	1 Battimore City NA	gn
	Aaryland start			wn or Location Baltimore 10d. Inside City Limit 1及Yes 2□N	
	with the A 3a or 28a-	il Direct	Maryland NA 10e. Street and Number 635 West Lexington Street	10f. Zip Code 10g. Citizen of What Country? 21201 USA	
36	urs after death	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes 2 □ No Specify: Puerto Rican Specify: white	
Maryland 21215-0036	within 72 hou ane. then *neture	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NA NA NA	
land ?	2 should be filed and Mental Hygie is marked other aumatic event, III	To Be C	17. Father's Name (First, Middle, Last) Christian Montoyo	18. Mother's Name (First, Middle, Maiden Sumame) Madeline Lorenna Figueroa	
	and 2 should lealth and Men m 27 is marke her traumatic			b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 West Lexington Street, Balt. MD 21201	
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		1 Rurial 2 Cremation 3 Removal from State	of Disposition (Name of ey, crematory or other place) Date 20c. Location - City or Town, State 20c Arundel Crematory 25 Oct 200 5 Odenton, MD	
Balti	permit. Departn Imports any inji		21. Signature of Funeral Service Licensee Domenico Omodeo MO1247	22. Name and Address of Facility Donaldson Funeral Home & Crematory 117A. 1411 Annapolis Road, Odenton, MD 21113	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line. If mmediate Cause (Final disease or condition resulting in death)	enticular dystunction British Between Onsel and Death Brown	<u>h</u>
8760,	Examiner bhysicien and the burial-transit	Ical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last Due to (or as a consequence of the consequence	c lett neartsyndnome igmont	H
.O. Box 68	The law requires that the death certifics attending phate has been signed by the attending phage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deceded to the pregnant at time of death 12 ☐ Fetal deceded to the pregnant at time of death 12 ☐ Fetal deceded to the pregnant at time of death 12 ☐ Fetal deceded to the pregnant at time of death 12 ☐ Fetal deceded to the pregnancy of the pregnanc	th 3 Ectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day Year	
٥.	w requires that been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting MULL WITH VENTO	in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 960 3 Probably 4 Unknow	٧n
Vital Records,	: The law requicate has been page 2 should	Completed by	•	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No	ile f
	Physician: Th this certificate ral director, pag	To Be		26. Place of Death (Check only one) Dutpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)	
Division of	Attending Pl		1 Matural 5 Pending (Month, Day Year) investigation	Time of 28c. Injury at Vork? 28d. Describe how injury occurred M 1 Yes 2 No	
Divis	in the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	the Hospital or thin 24 hours after the Funeral Div	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
)	To the vithin To the comple	Σ	29b. Signature and title of certifier Ruce 15. Vacuum 11.	29c. License number 29d. Date signed (Month, Day, Year) October 21, 2007	
3	Sta Registr		30. Name and address of pers. who completed cause of death (Item 23) 31. Date filed (Month, Day, Year) 32 Registrar's Signature	M. Wolfest. Hit move MD 2/2/7	

		•	State Amend Item 10	State of Maryland / De b per fh G850 12-	partment of Health and 14-05 tas ertificate of Death	Mental Hygien	2005 34180
	Dhysisi		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physicia /Medic			NESBIT		OCT 2	
	Examin	er	4a. Facility Name (If not institution, give s	and a	4b. City, Town, or Location of Dea	ith 2	Ac. County of Death
-	Francis		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	AUREL (ay) If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	PINCE GEORGES 9. Birthplace (State or Foreign
	Funeral Director			M 2 F 68 Yrs	Months Days Hours Mir	APRIL 18, 19	7 PENNSYLVANIA
	p ,		Usual Residence of Decedent	100 City Town	- Location		10d. Inside City Limits
	show	_	10a. State 10b. County Howard	10c. City, Town o	r Location		1 ☐ Yes 2 12 No
	the M	ect	10e. Street and Number	9(51)	10f. Zip Code	10g. C	Citizen of What Country?
	with Man	흐	9505 PARK AU	ENIE	20723	_	U.SA
	death with the Maryland ims 23e or 28e-f show r must be notified at	Funeral Director			13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
ဖွ	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 1 No Specify:	nto nican, etc.)	Specify: WHITE
21215-0036	72 hours efter natural', or Ite dicul Examina	d by	3 Widowed 4 Divorced	Year or Dates:		1.01	
15-	"nati	Completed	15. Decedent's Educ (Specify only highest grade	completed) (C	ecedent's Usual Occupation Give kind of work done during most of w fe. DO NOT use retired)	orking 16b.	Kind of Business/Industry
12	within sene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	CTRICAL ENGLHEER	60	DPARO SOACE CENTER
D	be filed within 72 hours efter death with the Marylan stal Hygiene. ad other then "neturel", or flems 23e or 28e-f show event, the Madical Exercitive must be notified at	0	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	en Sumame)
/lar	2 should be and Mental Is marked of aumatic eve	To B	N.	EAL NESBIT	BELVE	SWARIZU	VELDER
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ	- 1 12	lailing Address (Street and Number or I	- 0	1
-	1 and Health am 27 ther tr		RICHARD W-NESBIT		L WEST SUNSET LAN		Location - City or Town, State
Baltimore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ R	emoval from State cemetery,	crematory or other place)	24/0/ 0-1	Can Proving State
III.		1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		22. Name and Address of Facility	AT/OS DEV	TORU TENNSYLUANIA
Ba	permit. Depertr Importe any Inju		Duckas De	La sulla-	,	_	MARYLAND 21214
Ē	-		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. Do not	enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final	Metastatic Tor	_	unoma	Onset and Death
Г	/Medical		disease or condition resulting in death)	Due to (or as a consequence of)	is recal cui	aroma	111011035
	Examiner		Sequentially list conditions.				
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter the dentities Cause (Disease or injury	Due to (or as a consequence of)			
	xecuti and and	Examine	that initiated events resulting in death) Last	Due to (or as a consequence of)	:		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d				
9	tificate ig phy as the	a a					
Вох	eath certific attending p	Physician/M	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year
	the att	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		World Day 16a
0.0	that the de ed by the detached		9 ☐ Unknown Part II. Other significant conditions con	stributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ds,	ires the signer	1 by	Aven (C)	weight los	to disconying oddoo given in raix is	1 ☐ Yes	L
Vital Records,	w requir been si should	Completed	,	,		24a. Was an	24b. Were autopsy findings available
Rec	The lav	ш				autopsy performed?	prior to completion of cause of death?
ta	Icien: Th certificate ector, pag	0	25. Was case referred to medical		26. Place of D	1 ☐ Yes 2 2 ☐ 1 eath (Check only one)	No 1 ☐ Yes 2 ☐ No
	yslcie is cert direct	O B	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Other	Home 5 Residence	6 □Other (Specify)
0	ng Ph ter th	n: T	27. Manner of Death 1 SHatural 5 Pending	28a. Date of Injury 28b. Time (Month, Day Year)		28d. Describe how in	jury occurred
Sio	endir. or: Af he fur	atic	2 Accident investigation		M 1 Yes 2 No		
Division of	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
ш	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director, it	edical Ce	(Check only 2 Medical Examin	ner: On the basis of examination and/	feath occurred at the time, date and pla or investigation, in my opinion, death oc		
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	~\ 5 ₹ 5 8		Poten	el	123999	8 /	10-20-05
ĵ	DY		30. Name and address of person who co	empleted cause of death (Item 23a) (To	(pe, Print) PRITAN	5 001.	VIMD
	U		9101 chen	y Lone Si	11- 211 Lours	20 Ma	20738
	Sta		30. Name and address of person who co	32. Signature	South .		
	Regist	rar	UU 1 2 4 20	UU Jacobson John	STORE		

nd / Department of Health and Mental	Hygie	n)e []	n	5
Certificate of Death		L V	U	V

			For State Registrar	State of Maryland / L	Certificate of	Death	Reg. N		34181
, Ā.	Physici	an	1. Decedent's Name (First, Middle, Last)		cetlow	2	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Shanika 4a. Facility Name (If not institution, give			r Location of Death	OCT. 18	3, 2005 4c. County of Death	0748 A M
100	Examin	er	MARYLAND GENERAL	HOSPITAL	BALTIM	ORE CITY		NA	
	Funeral Director		5. Social Security Number 6. Security 1217–94–0206	14 of r	htday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	8. Date of Birth (Month, Day, Yea 8-24-79	9. Birth	place (State or Foreign intry) Md.
	yland how		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	8a-fs	ector	Md. NA]	Baltimore				XXYes 2 □ No
	s 23a or 2	Funeral Director	3123 Windsor Blv		10f. Zip Code 2120			USA	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. od other then "nsturel", or flems 23a or 28a-f show event, the Medical Examinat must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	Specify:	izy resor No- ican, etc.)	14. Race - Amen Black, White Specify:	
15-0	"nstu	Completed by	15. Decedent's Edu (Specify only highest grad	cation 16a. e completed)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	16b.	Kind of Business/I	ndustry
2121	fited within Hygiene.	ошо	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	Unemployed	1)		NA	
nd	be filed trail Hygie of other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (
ylaı	2 should be filed with and Mental Hygiene Is marked other the aumatic event, La I	10	Larry	Pretlo		Jestine		McBeth	
Mar	ges 1 and 2 should to f Health and Mer If frem 27 is marke or other traumatic		19a, Informant's Name/Relationship (Ty		. Mailing Address (Street 3123 Windsol				
	s 1 and of Health ttem 27 other tr		Jestine McBeth 20a. Method of Disposition	20b. Place of	Disposition (Name of	Dat	The second second second	Location - City or T	
E O	Pages vent of int: If it		1 Buriai 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	semoval from State	y, crematory or other plac Carmel Cem.	10-25	5-05 D	oundalk, M	id.
Baltimore,	permit. Pages Department of I Important: If ite sny injury or of		21. Signature of Funeral Service Licens	00	22. Name and Addre	ss of Facility	Baltimo		21202
	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	inshot War	4	respiratory arrest,		Approximate Interval Between Onset and Death
e.	Examiner pansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of).				
68760,	ficate be executed physicien and is the burial-transit	edical Exa	resulting in death) Last	Due to (or as a consequence	of):				
	artifica ing ph e as th		IF FEMALE:			_			
.O. Box	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1	3 □Ectopic pregnancy 5 □ Other (specify)	/		23d. Date of deliv Month	rery Day Year
Ω.	quires that in signed b uld be deta	ρ	Part II. Other significant conditions col	ntnbuting to death but not resulting in	n the underlying cause giv	ren in Part I.		o use contribute to	the cause of death?
Il Records,		Completed					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	testions 35 BOA Oth	26. Place of Death			
of	ding After fune	ation: To	1X Yes 2 No 27. Manner ol Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	Firme of 28c. Injur	4 Nursing Home	e 5 Residence d. Describe how in	6 □Other (Speciality occurred	bject was
Division	To the Hospital or Attanwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)			If. Location (Street City or Town, Sta Bultimore	and Number or Rur ate) 800 M	al Route Number, KRUAN AVE.
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in h	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	e, death occurred at the tire d/or investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause	(s) and manner as	stated. to the cause(s)
	To t To t	E	29b. Signature and title of certifier	4/ 5	29c. Licens OCI			Date signed (Month,	
	1		30. Name and address of person who co		(Type, Print) 111 Pe	enn Street		CT. 18, 2 re, Maryl	and 21201
7.	Sta	ate.	31. Date filed (Month, Day, Year)	Registrar's Signature	1 11.0				
8	Regist		OCT 2 4 200	5 Blown St. A	Joseph				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Naomi Perrott October 21, 2005 РМ 7:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Woods Nursing Center Rosedale <u>Baltimore</u> If Under 24 Hrs. 5. Social Security Number If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year, 6. Sex 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) Hours 1 □ M 🛠 🗜 F Director 90 225-32-8703 Jan. 23, 1915 Ohio Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Neulcal Examinat must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Essex Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1913 Eastern Avenue, Apartment #106 U.S.A. 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Yes 2 🗖 🛭 o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: ۵ Specify. 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 Sales Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Duell Lottie Ackelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traum Sheila Wagner (Daughter) 13210 Patuxent Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith Oct. 26, 2005 Baltimore, Maryland 21. Sig atura di Futto di Govice Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Ater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease of condition resulting in death) Onset and Death **Physician** Multiple /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Nemia 1 Yes 2 No 3 Probably Completed Deen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53462 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ortwood Road Glen Burnie 7845 Jude Woneser MP 31. Date filed (Man) 32. Registrar's Signature State Registrar

		. 1	For State Registrar	State of M		artment of H		nd Mental Hy	giene	5 34183
			Decedent's Name (First, Middle, Lateral	st)				2. Date of De	ath	3. Time of Death
	Physici /Medic		VAMES	RUSS	>			Month OETEA		Year ZIA
	Examin		4a. Facility Name (If not institution, give	1 -	0	4b. City, Town, or	r Location of	Death	4c. County o	
			Nonthives	r HESPI		2.A	MOAL	1stown		4 itimibre
	Funeral		5. Social Security Number 6. S	ex [7.Ag ∑X M 2□F	e (In yrs. last birthday, 81 Yrs.	Months Days	If Under 2 Hours	Min. (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		216-14-4488 Usual Residence of Decedent		0.1			May 1	, 1924	Maryland
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Mar	Director	MD Baltim	ore	Rei	sterstov	wn			1 □Yes XXNo
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	nat Country?
	ath w	ra	1012 Berrym	1			21136		U.S	
	ier de Items	Funeral	11. Marital Status 1 Never Married XXMarried	12. Was Decedent Armed Forces? **XYes 2 :	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
336	al', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII	1□Yes XXNo	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or Items 23e or 28e-f show in Maryleal Examena must be modified at	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	a fi con delin a	16b. Kind of Bus	iness/Industry
218	thin 7 e. "r	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+) life.	e kind of work done of DO NOT use retired	d) -	ai working		
	filed w Hygien other th			1		Tool Mak				acturing
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumetic event, The M.	Be	17. Father's Name (First, Middle, Last, John C. Ros					's Name (First, Middle)
7	should and Men marke umetic	10	19a. Informant's Name/Relationship (10h Mail	ing Address (Street		ylvia Tu: r or Rumal Route Numb		tate Zin Codo)
Ma	th an Ith an treu		Sharon Koenig							MD 21136
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygiens. Department of Health and Mantal Hygiens important: If item 27 is marked other than "naturel; or Items 23e or 28a-1 show any injury or other treametic event, Ita Maulical Exameter must be notified at any injury or other treametic event, Ita Maulical Exameter must be notified at any injury or other treametic event, Ita Maulical Exameter must be notified at ange.		20a. Method of Disposition		20b. Place of Disp		1	Date		ity or Town, State
Ë	Pages nent of I int: If its iry or o		XXBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif		Evergr Memorial	een	G	10/25/05	Finles	huma MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	1900	Premor Tal	2. Name and Addres	ss of Facility	Eckhardt	Funeral	Chapel P.A.
Δ.	88 2 5 8		Hof Eclil	andt						II11s,MD21117
г			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each li	ne.	-				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ARDIOGR	NIC	SHO	CK		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	a ai	22 %	ango pai		
L		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	_	sc bh o	my pac	my	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events							
o,	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):					
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Вох	ath certifi attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date Mont	of delivery h Day Year
o.	that the de ed by the detached	ysic	1 Yes 2 No	9□ Unknown	time or death 3	Other (specify)				
Δ.	res that the igned by be detact	by Ph	Part II. Other significant conditions of	antributing to death t	out not resulting in the	underlying cause give	en in Part I.	23e. Did t	obacco use contrib	rule to the cause of death?
rds	quires an sign uld be	q pe	Concary to	tony 01	SEASE S	TATUS P	057	1	Yes 2 No 3	B ☐ Probably 4 ☐ Unknown
Records,	aw requir is been si 2 should	Completed	Concratny An	tory By	PASS AM	O GRA	FT	24a. Was		ere autopsy findings available for to completion of cause of
E E		mo:	STATUS PECT	NALANTA	BLE DE	FiBnilla	Ton	perfo	ormed? de	ath?
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					of Death (Check only of	one)	
of \	Physician: this certifical director,	ို	1 ☐ Yes 2 ☐ NO	Hospital:				sing Home 5 Resi		
on (ding F h. After funera	lon:	27. Manner eath 1 atural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	Wor	yat k? Yes 2 ⊟ N		how injury occurred	d
Division	Attending r death. sctor: After by the fune	licat	2 Accident investigatio 3 Suicide 6 Could not b	e Joe Blace of le	ury - At home, farm, si		143 5 1		Street and Number	or Rural Route Number.
Ρ	after after Dire	Certification:	4 Homicide determined	building, e	c. (Specify)	,,,		City or To	wn, State)	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Pt	ysician: To the best	of my knowledge, dea	th occurred at the tin	ne, date and	place, and due to the	cause(s) and man	ner as stated.
	he Hk in 24 he Fu pletel	Medical	(Check only 2 Medical Examone)	and manner st	if examination and/or in ated.	ovestigation, in my o	pinion, deat	h occurred at the time,	date and place, an	d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Mes		29c. License	e number	3		(Month, Day, Year)
	T			HAMAS	> mg	10/9	430		VECOSSE	2 21 2865
4			30. Name and address of person who			Print)	N	MIHWE!	7 48	12 2165 SPITAL CENTER AND 21133
į.	Sta	ato.	On (A-DDO B) 31. Date filed (Month, Day, Year)	-0	rar's Signature	RA	WON	1570m N	muny C	AND 21133
	Regist			05	w K A	code			,-	

			For State Registrar	State of Mary		artmen <i>rtificat</i>			nd Mer		ene 9. N2 0 0 5	34184
	hysici		1. Decedent's Name (First, Middle, Last) A / BE2-T	K.	RICH	492	150	N		Date of Death Month	Day Yea	3. Time of Death 12/30 AM
1 1 1	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)				Location of		,	4c. County of De	-
		.5	JOHNE HOPKINS BAY	VIEW NEDIC	ALEMA	*	BA	277/	non	=	N/A	
	ineral rector		5. Social Security Number 6. Sex 120 6. Sex	7. Age (In	yrs. last birthday) 34 Yrs.	If Under Months		If Under 2 Hours	Min. A	Date of Birth (Month, Day, Oril 20	9. E 0, 1921	Birthplace (State or Foreign Country) Maryland
and	A	 	Usual Residence of Decedent 10a. State 10b. County	100	c. City. Town or Lo	ocation						10d. Inside City Limits
в Магу	Sa-f eho	ctor	Maryland N/A		Balti	imore						1 X Yes 2 □ No
ih th	or 21	Dire	10e. Street and Number			10f. Zip				10	g. Citizen of What	
athy	230	ra	3801 Grenton Av					1206			United	
21215-0036 of within 72 hours after death with the Maryland rgiene.	nd other then "naturel", or items 23s or 28s-f show event, the Mudical Examinar mant be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	 12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 194 		Was Dece If Yes, spe 1 \(\text{Yes} \)		spanic Orig n, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Al Black, W Specify: W	
5-0	natur	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usu	al Occupa	ation Juring most	of working		6b. Kind of Busine	ss/Industry
within within ene.	W W	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired,	rmast			II C No	1.01
d 2 filed v	nt, th		12 yrs. 17. Father's Name (First, Middle, Last)		CIT	eı Qı	Jai Le			ione Adiabath A	U.S. Na	vy
Maryland of 2 should be file the and Mental Hy	narked of	To Be	William Richa					М	lildre	d Ke	faiden Sumame) lly	
C 0	127 14		19a. Informant's Name/Relationship (Ty) Mrs. Gertrude M. R	•				_{ind Number} on Ave			City or Town, State	a, Zip Code) 21206
S 1			20a. Method of Disposition	1	Ob. Place of Dispo cemetery, cre	osition (Nai	me of	į.	Date		20c. Location - City	
Pages Pent of	Important: If any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 💢 Other (Specify)		Parkwood	•		· 1	ct.24	.2005	Baltimor	e, Maryland
Balti permit. Depertir	mporte any nju		21. Signature of Funeral Service License	Michael E. C	anapp 2	2. Name ar	nd Addres	s of Facility	,	53	305 Harfor	rd Rd.
m &ă	트등점		· Mace.	7.1.				J. Ru			ıltimore,	MD 21214
100	sician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the le cause on each line. Due to (or as a co				g, such as c	cardiac or re	spiratory arre	st,	Approximate Interval Between Onset and Death IZ HRS
	edical miner		resulting in death)	Due to (or as a co	nsequence of);							4 7
		- a	Sequentially list conditions,	Que to (or as a co	EMON	4						= DAYS
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oxec	iclan and burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):							
8760 cate be e	ohysician the buria	dicai										
refilica	ng ph	Med	IF FEMALE:						,		1	1
I Records, P.O. Box 68760, <. The law requires that the death certificate be executed	by the attending parached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pi ⊒ Other (sp					23d. Date of o Month	delivery Day Year
Jat that	de de	y Ph	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	underlying o	ause give	en in Part I.		23e. Did tob	acco use contribute	to the cause of death?
Vital Records, sicien: The law requires t	n sign uld be	ed by								1 □ Ye	s 2. 1 No 3□	Probably 4 □Unknown
S W F	s been si 2 should	Completed								24a. Was ar	24b. Were	autopsy findings available o completion of cause of
He t	page	E O								autopsy perform 1 Yes 2	ied? death	o completion of cause of ? es 2 \(\sum \text{No} \)
	certifica rector, p	Bec	25. Was case referred to medical				455 51.3	26. Place	of Death (C	heck only one		65 20140
	w 0	Tof	examiner? 1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatie	nt 3 DC	Othe	er: 4 □ Nur:	sing Home	5 Reside	nce 6 Other (S	Decify)
0 L	After th funeral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	of 2	28c. Injury Work				w injury occurred	
Vision Attending	tor: A the fu	cati	2 ☐ Accident investigation			М	1 🗆 1	Yes 2□N	lo			
Division of all or Attending Phy s after death.	O >-	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factor	y, office		28f.	Location (Str City or Town	eet and Number or , State)	Rural Route Number,
Hospital 24 hours a	To the Funeral Dire completely filled in b	edical (29a. Certifier 1 Certifying Phys	sicien: To the best of my ier. On the basis of exa and manner stated.	y knowledge, dear mination and/or in	th occurred ivestigation	at the tim	ie, date and pinion, deatr	place, and n occurred a	due to the ca	use(s) and manner ite and place, and d	as stated. lue to the cause(s)
To the within 2	Го th	Me	29b. Signature and title of certifier	0 0		290	c. License	number		29	d. Date signed (Mc	onth, Day, Year)
- 5	- 0		· inull	let F	c 11 s	P	FS	-0	\sim)	10/21	105
	1		30. Name and address of person who co			Print)	1-0				10101	
4	2			e	MILLA		PIT	SV	4940	Easte	on Ave	Baltimore Mi
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 4 2005	32. Registrar's S	Signature	A SECOND						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 00 - 50A M aluin october 2005 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital of USA Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 212-34-5529 1**X**M 2□ F Director mary Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show Baltmore Be Completed by Funeral Director 1 XYes 2 □No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. I □ Yes 2 2 No If Yes, Give" Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 □ Yes 2/2 No lac 3 ☐ Widowed 4 2 Qivorced Specify: "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry OF reau Elementary/Secondary (0-12) College (1-4or 5+) aborer 12-14 Parks it of Health and Mental Hyg If itam 27 Is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Slights Marcel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smith 8840 Sister Kosa liee Kate Kandallstonn, md, 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) bate 20a. Method of Disposition 12 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. 10/25 ion Com 4 □ Donation ☐Other (Specify) 21. Signature of Fineral Service Lice 22. Name and Address of Facility Pass 270 Fred HILTON P. marcit Reneral Home Bacto md, 21229 23a. Part Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer **Physician** Lung 8 months /Medical Due to (or as a consequence of): Examiner Preumonia 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to to as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the hours transfer. Due to (or as a consequence of): Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Year

Ö

Records, P.

Division of Vital

Certification: To Be Completed by Physician/Medical

in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month Day

2 No 3 Probably

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2 No 1 Yes

1 Tes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

4 Unknown

25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural

5 Pending investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide

and manner stated.

1 ☐ Yes 2 ☐ No

28f Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number RESIDENT-19076 29d. Date signed (Month, Day, Year)

october, 20, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITA L PRANITHA NAINI SINAL

31. Date filed (Month, Day, Year) State Registrar

29a, Certifier (Check only one)

2005

and



MD

Penny Smith 05-07122 CT

0,1.			State of Maryland / Department of Health and Mental Hyginstate Unpend Item 23a&27 per me G850 Certificate of Beath	ie2e005 34186
3	Physici /Medic		1. Decedent's Name (First, Middle Last) 2. Date of Death Month October	Day Year
6430	Funeral Director		4a. Facility Name (If not institution, give street and number) 9109 Liberty Road 5. Social Security Number 6. Sex 1	4c. County of Death Baltimore 9. Birthplace (State or Foreign Country) Maryland Maryland
	the Marylan 28a-f show	ctor	10a. State 10b. County 10c. City, Town or Location Rand all storn	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with th	rai Director	10e. Street and Number 8300 Hilmar Ct. 21244	0g. Citizen of What Country? USA
9800	ours after death with the Maryla ral', or Iteme 23a or 28a-f shov Examiraer must be mottlised at	d by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent tof Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent tof Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent tof Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent tof Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Hadde
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. diother than "natural", or Iteme 23a or 28a-f show event, The Medical Exertain minal be redillised at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	16b. Kind of Business/Industry Domeotic
Maryland	be d la la la la la la la la la la la la la	To Be (17. Father's Name (First, Middle, Last) Skrling C, Smith 18. Mother's Name (First, Middle, Mary H	Maiden Sumame)
Baltimore, Mar	es 1 and 2 sh of Health and of Hem 27 is m r other traum		Committee 2 Committee 2 Democration State Committee Committee Committee	
Balt	permit. Page Department. Important: If any Injury o		21. Signature of uneral Service Licenses 22. Name and Address of Facility 27.0 Fred HILTON F	PASS one Beeto, md. 21229
	Physician /Medical Examiner parisisted and price literal parisisted and pr	Examiner	shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Due to (or as a consequence of): Due to (or as a consequence of):	Interval Between Onset and Death
Box 68760,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be defached for use as the burial-transit	dicai	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
P.O. E	that the dea ed by the at detached fo	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	Month Day Year
	w requires that been signed should be det	þ		pacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 ☑Unknown
Vital Records,	sician: The law r certificate has be rector, page 2 sh	e Completed	25 Was one referred to medical	y prior to completion of cause of death? One of the prior to completion of cause of death?
Division of Vi	Attending Physicis death. ctor: After this cert y the funeral direct	Certification: To B	examiner? Name 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Reside 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 29d. Describe ho	once 6 ⊋Other (Specify) Scene ow injury occurred
Divi	To the Hospital or Attank within 24 hours after death To the Funeral Director: completely filled in by the	1 1	4 Homicide determined 289. Place or injury - At norme, farm, street, factory, office 281. Location (Str. City or Town) 299. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the care.	ause(s) and manner as stated
	To the Ho within 24 To the Fu completel	Medical	(Check only and manner stated. 29b. Signature and attemption of the basis of examination and/or investigation, in my opinion, death occurred at the time, day and manner stated. 29b. Signature and attemption of certifier and manner stated.	ate and place, and due to the cause(s) 9d. Date signed (Month, Day, Year) October 21, 2005
l	T			imore, Maryland 21201
Physical Section 1985	Sta Registi	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 17 Rev 1/2001

			- FOI	ryland / De	epartment of Hea	alth and M		iene nns	21.100
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of De	eath	2. Date of Deat		3. Time of Death
	Physici /Medic		Walter N Smit	-4			Month	12 2 300	
	Examin	er	4a. Facility Name (If not institution, give street and number) GOOD Samarifan Ho	spital	4b. City, Town, or Lo	nozetion of Death		4c. County of Dea	ıth
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 1	(In yrs. last birtho	Months Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 19,	Year) 9. Bii	thplace (State or Foreign ountry) unk
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o					10d. Inside City Limits
	he Mar 28a-f s	Director	MD 10e. Street and Number	Ba1	timore		1.	0g. Citizen of What C	1X Yes 2 No
	23a or	ai Dir	5409 Mayview Avenue		Tor. Zip Code	21206		USA	ountry :
136	hours after death with the Maryland tural', or flems 23a or 28a-f show al Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispa If Yes, specify Cuban, 1 ☐ Yes 2√2 No	anic Origin? (Spo Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
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717	be filed within 72 ha stal Hygiene. Ind other than "natus event, the Miscial	Сотр	Elementary/Secondary (0-12) College (1-4or 5+ unk	-)	disabled			none	
and	buld be file Mental Hy arked oth atic event	Be	17. Father's Name (First, Middle, Last)		unk 18	8. Mother's Name	(First, Middle, M	Maiden Surname)	unk
Maryland	nit. Pages 1 and 2 should be filled artment of Health and Mental Hygi ortent: If item 27 is marked other injury or other treumatic event.	ဥ	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and				
	Health item 27 other tr		Janell Broadway/friend 20a. Method of Disposition	20b. Place of D	09 Mayview A			e, MD 2120 20c. Location - City o	
Baltimore,	Pages nent of ant: #fit ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☑ Other (Specify) in state	cemetery,	crematory or other place)	1			
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Ronald S Wade Dare	etor	22. Name and Address of State Anato	BINDS TO BE STORED		Baltimore	e Street
	Physician /Medical		23a. P.+1. Enter the disease or emplications that caused in short, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)	Mall (enter the mode of dying, s	such as cardiac		est,	Approximate Interval Between Onset and Death
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O. Box 6	Attending Physician: The law requires that the death certificat rideath. sctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	blivery Day Year
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Vital	rsician s certifi	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital: 1 Xinpatier	nt 2□ER/Outp	Other	6. Place of Deatl		ence 6 Other (Sp	ecify)
Division of	nding Phys th. : After this s funeral di	tion: T	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident investigation	/ 28b. Tin	ne of 28c. Injury at Work?			ow injury occurred	outy)
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	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of Examiner: On the basis of and manner stal	examination and/	death occurred at the time, or investigation, in my opin	date and place,	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of centrier	ed.	29c. License n	number	2	9d. Date signed (Mor	
)			Du Pineles	イ・1ン.	126	3382		10,12,6	1005
			30. Name and address of person who completed cause of de 5601 Loch Raven Blvd.	atn (Item 23a) (T)	imore, M	10 21	239		
	St. Regist		31. Date filed (Month, Day, Year) 32 Registra OCT 2 4 2005	r's Signature	parke				

			For State Registrar	State of Mary	land / D	epartment of F Certificate of t	lealth and Death		en 2 () () 5 g. No.	34189
*()	Physici /Medic	100	1. Decedent's Name (First, Middle, Last Shirley Smith	')				2. Date of Death Month	Day Year /5, 200	
	Examin		4a. Facility Name (If not institution, give SACRED HE.	ART HUS	pita	- Cumi	Location of Deat	d	ALLE	cany
	Funeral Director	Ši.	5. Social Security Number 227–42–2237 Usual Residence of Decedent	TM 2FIE	n yrs. last birth	Months Days	If Under 24 Hrs Hours Min.		^{9. B} 1935	irthplace (State or Foreign Country) Virginia
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-1 ehow Ita Medical Examinat must be notified at	Director	10a. State 10b. County MD Allegan		oc. City, Town	stburg				10d. Inside City Limits 1 □ Yes 2 □ No
	e 23a or 2	eral Dire	10e. Street and Number 164 E. Main Street		rio II C		1532		USA	
036	urs after de al', or Item Ever-doetr	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Oecedent Eve Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:	or in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (San, Mexican, Puer Specify:	to Rican, etc.)	Black, Wh	nerican Indian, lite, etc. white
21215-003	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or Iteme 23a or 28a-1 ehow marked other than "natural", or Iteme 23a or 28a-1 ehow marked other than "natural be roullied at imatic event, the Medical Evantuar must be roullied at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	during most of wo	rking GTIR	6b. Kind of Busines	
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, Maryland	nd 2 sith ar	-	19a. Informant's Name/Relationship (7 Stacy Welch/dau	ype, Print)		Mailing Address (Street 730 Schoone	and Number or R	ural Route Number,	City or Town, State	, Zip Code)
altimore,	permit. Pages 1 a Depertment of Hee Important: If Item any Injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State	cemetery	Disposition (Name of crematory or other place	1		Oc. Location - City o	
Ball	permit Depert Import any in		21. Si hatu us Funeral Ser ice Licen. Rona 1 d S	MI BEEL		22. Name and Addre State Anat Baltimore,	MD 212	0.1		
ja Ja	Physician /Medical		shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	OUS CEI	L CARCINO			st,	Approximate Interval Between Onset and Death ADAYS
,8760,	Examinet be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of	·):	3 . A C			
P.O. Box 68	death certiff e ettending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of o	lelivery Day Year
	quires thet an signed b uld be deta	by	Part II. Other significant conditions co	ontributing to death but r	not resulting in	the underlying cause giv	en in Part I.			to the cause of death? Probably 4 □Unknown
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detached.	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to death	autopsy findings available of completion of cause of completion of cause of completion of cause of completion of cause of completion of cause of completion of cause
Vita	sician s certific irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Out	patient 3 DOA Oth	00	ath <i>(Check only one</i> Home 5 \subseteq Reside		
ion of	utending Phy death. ctor: After this / the funeral d	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		me of 28c. Injur		28d. Describe ho		<i>веспу)</i>
Divis	or A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, fan Specify)	m, street, factory, office		28f. Location (Str City or Town	eet and Number or State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medicai	29a Certifier (Check only one) 2 Medical Examone) 29b. Signature and title of certifier	sician: To the best of a liner: On the basis of ex and manner stated	amination and	for investigation, in my o	pinion, death occ	urred at the time, da	te and place, and d	ue to the cause(s)
	¥ × 8		30. Name and address of person who	DR. WIRAS		SNAIN DE	53118		10/15/2	005
			WIRACAT HACK	AIM. IM.D.	900	SETON DRI	VE Cum	BERLANI	D, MD	21502
	St. Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 4	32. Rebistrar's	Signatur	Agares				

CTPlease Type or Print in Black Indelible lak, Ensure All Copies Are Legible. Pend 1 Emil 23a, 27, 28a-1, permit, 6848, 10/26/05 The State of Maryland / Department of Health and Mental Hygiene 05-07018 John L. Thorne 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15 October 0 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 2410 Wilgrey Court Baltimore Social Security Number 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□ F 20 06-5355 d0-Yrs **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location worke 10d. Inside City Limits itam 27 is marked other then "neturel", or iteme 23a or 28a-f ehov other traumatic event, the Modical Examinar must be notified at Baltimore mo 1 Yes 2 No Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 USA d41 death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1□ Yes 2☑ No Specify þ 10 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10th Tuden NIA 17, Father's Name (First, Middle, Last) 18. Mother's Name (First_Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant; if Itam 27 is marked oth Be iona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) circle Latona 1002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ita 188urial 2 Cremation 3 Removal from State injury or 4 □ Donation 5 □ Other (Specify) Carne of Juneral Service License eny. of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate ause (Final **Physician** disease or condition resulting in death) Contact Gun Shot Wound of Head /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) ettending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 5 Other (specify) ihe i 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 99 Completed 1 Yes 2 × No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2□ No Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one. examiner? Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) Scene 2 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Prid Pate of Injury Fire of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 10/15/05 1 ☐ Yes 2X No 7:27 P death. 2 Accident Subject shot self filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number of Rust Route Number Court City or Town, State) 2410 Wilgrey Court within 24 hours after To the Funeral Dire 4 | Homicide Scene Baltimore, MD the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

31. Date filed (Month, Day, Year) 2005 OCT 2 4

29b. Signature and title of certifier

ANA



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

October 16, 2005

29c. License number

O.C.M.E.

Registrar

DHMH 17 Rev 1/2001

ODIGINIA

State of Maryland / Department of Health and Mental Hygien 0 0 5 For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tober **Physician** 25 Almarie Wedley Beatrice /Medical 4b City, Toyon, or Location of Death 4a. ility Name (If not institution, give street and number) 4c. County of Death Examiner saltimore land General If Under 1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yts. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M **X**(X)F Months Days Min Yrs. Director 234-40-6292 82 WV Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ahow traumatic avant, the Medical Examiner must be notified at Yes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 220 Whittier Ave
11. Marital Status
1 Never Married 2 Married Itama 23a U.S.A.

14. Race - American Indian,
Black, White, etc. 21217 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes X☐ No Black ģ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Baltimore City permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than 'any fujury or other traumatic avant, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 8yrs Teacher School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Charles Clark Elnora Sheffey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Smith-Daughter 5520 Lynview Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Baltimore Co, Md 10/24/05 21. Signalu of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** 515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 Inpatient 2 ER/Outpatient 3 DOA hours after death. Ineral Diractor: After this y filled in by the funeral di After this 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month 32. Registrar's Signature State

Registrar

4 2005

State of Maryland / Department of Health and Mental Hygien 2005
Certificate of Death

7			For State Registrar	State of M	arylar				leaith ai Death	nd Me		ien 2 0	05	3419	3
			1. Decedent's Name (First, Middle, La	ist)						2	Date of Deat	h		3. Time of Death	
	Physici		Delpatrick	P	urne	ell		Wes	son		Month Octobe	r 20	Year 2005	8:45p.	М
	/Medic Examir		4a. Facility Name (If not institution, gire				4b. City	Town, or	Location of		oc cobe		ity of Death	0.430.	
			Gilchrist Nurs	ing Home			ŗ	lows	on				ltimo	re	
	Funeral	32.5			је (In yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under 2	4 Hrs. 8 Min.	. Date of Birth (Month, Day,			ace (State or Forei	gn
-127	Director		210-90-3393	™ 2□ F	36	Yrs.	NOTITIES	Days	Hours		10 08			MD	
	and *		Usual Residence of Decedent 10a, State 10b, County		10c Ci	ty, Town or Lo	ncation						14	Od. Inside City Limit	-
	daryl f eho	ō	MD NA			altimo							"	1 X Yes 2 □ N	
	death with the Maryland me 23s or 28e-f ehow frust be notified at	Funerai Director	10e. Street and Number				10f. Zip	Code			11	Og Citizen o	f What Coun		
	3a or	ā	2111 Rupp Stre	et					1217			-	S.A.		
	me 2	Jera	11. Marital Status	12. Was Decedent		J.S. 13.	Was Dece	dent of Hi	ispanic Origi	in? (Specif	fy Yes or No- can, etc.)	14. Ra	ace - America	an Indian,	
9	after or its	Ē	1 Never Married Married	Armed Forces?		1			n, Mexican, Specify:	Puerto Ric	can, etc.)		ack, White,		
903	hours tural', a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			10 105	201 NO	<i>Specify</i> :			Spec	ify: B	lack	
5-("natu	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usu kind of wo	al Occupa ork done d	ation during most of	of working		6b. Kind of	Business/Ind	ustry	
21215-0036	within ene. then "	Completed	l2th grade	College (1-4or	5+)	Auton						Autor	nobil	e, Shop	
	d 2 should be filed within ? h and Mental Hygiene. 7 ie marked other then "! traumatic event, the M. of	ပိ	17. Father's Name (First, Middle, Last								First, Middle, N				_
Maryland	ld be ental ked c	To Be	Eddie Wesson						Lois						
ary	shound M	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address				Route Number,	City or Town	n. State. Zip	Code)	
Ž	alth a		Paulette A. We	sson-Wif	е						ltimor			217	
re,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent; if Item 27 is marked other then "natural", or Iteme 23a or 28e-f show amp injury or other traumatic event, the M. dical Exemples changes and once.		20a. Method of Disposition		20b. I	Place of Dispo cemetery, crer	sition (Nai	ne of	o)	Date	Θ 2	Oc. Location	- City or Tox	vn, State	
Baltimore,			1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci			ng Mem				10/26	6/05	Randa	allst	own, md	
alti	permit. Departn Importe any inju	Ì	21. Signature of Funeral Service Lice	nsee h		22	. Name ar	nd Addres	s of Facility						-
<u> </u>	8988		XVIVIIII	U.VXU	116	43	168 r	งล็อลี	sheat	ie, l	Baltim	ore,	Md	21215	
			23a. Parf1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the deal	th. Do not ent	er the mod	le of dying	g, such as ca	ardiac or r	espiratory arre	st,		Approximate Interval Between	
h	Physician		Immediate Cause (Final disease or condition	CAN	CEL	OF	2	ARY	NX					Onset and Death	
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	quence of):									
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Вох	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. D	ate of deliver	v	
-	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pr Other (sp							Day Year	
P.0	at the by th	Physician/Me	9 🗆 Unknown	9□ Unknown											
	The law requires that the death certificate be executed its has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	þ	Part II. Dther significant conditions	contributing to death b	ut not res	sulting in the ur	nderlying c	ause give	n in Part I.		23e. Did tob	acco use cor	ntribute to the	cause of death?	
Records,	w requir been si should	Completed								_	1 ☐ Ye	s 2□No	3 ☐ Proba	bly 4 Unknow	n
eC	has be	pie									24a. Was an autopsy		. Were autop	sy findings available	Θ
	The zate h	S									perform		death?	Piolion or dause or 2□ No	
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?						26. Place o	f Death (C	Check only one)			
of	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatien			4 LI NUI'S					Nospice	
n	ding I	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		8c. Injury Work			d. Describe how	v injury occu	rred		
Sign	death ctor: / the	cat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 200 Place of Ini	un/ - At h	omo form et-	M		fes 2 □ No		Location (Ctr.				
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	withii To th comp	Ň	29b. Signature and title of certifier				290	. License	number		29	d. Date signe	ed (Month, D	ay. Year)	
	9		Menen	com			2)58	303		0	rose	2 21	2005	
-	3		30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type,									
0	×-		7	arles mo	6		J. (Us	ele	12	tom 50	NN	D 2	204	
	Sta Registr		31. Date filed (Month Day Year)	2005 32. Report	ar's Signa	ature	Lac. M								

DHMH 17 Rev 1/2001

			1 - State of Ma	aryland / Depa <i>Cei</i>	artment of F	lealth and Me Death	ental Hygier		34194
4		je.	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medio		John Prentice Zill, Jr.				Month / 21	/ 200 S	-2274M
)	Examir	ner	4a. Facility Name (If not institution, give street and number) FOR ALKLIN SQUARE HOS 5. Social Security Number O. Sex 7. Age		4b. City, Town, o	T Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	BALTI 9. Birth	Pho C 2. Phologophy Company C
	Director		218–28–8875 ^{1™ 2□ F}	75 Yrs.	World's Days			1930 Mar	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary	ō	Maryland Baltimore	Middle Ri	ver				1 ☐ Yes XX No
	1 the	rec	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Cou	intry?
	h with	Funeral Director	3522 Buck Board Lane		21220		U.	S.A.	
	deat	ner	11. Marital Status 12. Was Decedent I Armed Forces?	1	Was Decedent of H	dispanic Origin? (Spec an, Mexican, Puerto R	ofy Yes or No-	14. Race - Amer	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturei", or iteme 23e or 28e-f ehow event, the Medical Exerties must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N 1 ☐ Yes, Give 3 ☐ X Widowed 4 ☐ Divorced Year or Dates:	。1951- 1953	1 ☐ Yes 2 <mark>%</mark> No	Specify:	ican, otc.,	Black, White	ite
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	pation	16b.	Kind of Business/Ir	ndustry
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	filed with Hygiene other the		12	Mach	inist	18. Mother's Name		lecommun:	ications
Maryland	should be filed within and Mental Hygiene. Tharked other then imatic event, to a Mi	Be c	John Prentice Zill			Catherine		in Sumame)	
Ž	s 1 and 2 should it Health and Men item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	and Number or Rural		or Town, State, Zi	p Code)
	27 is		Charmaine Levie (Daughter)			nue, Notti			
Je,			20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place	Da	te 20c.	Location - City or T	own, State
Ē	Pag nent ant: i		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bayview C			,2005 Bal	timore, 1	Maryland
Baltimore,	permit. Page Department of important: if eny injury or		21. Signature of Fugeral Service Licensee	22	Name and Addre	uzdzinski Eastern Av	Funeral H enue. Ess	ome, P.A.	land 21221
* 4			23a. Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not enti-					Approximate Interval Between
1	Physician		Immediate Cause (Final dispase or condition	10Al	AORIF	ic St	enos	15	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a	consequence of);		1 9 1	0,- 0 3		
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D. Box	Physician: The law requires that the death certific this certificate hes been signed by the attending r rai director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	1	-	23d. Date of deliv Month	rery Day Year
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Vital Records,	w requires to been signer should be	ted by	Hepatic FA	ilure	idonysig cadso giv	on an and a			bably 4 Unknown
ecc	iawr ies be ies be	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available
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o	Phys this ral dir	<u>۲</u>	1 ☐ Yes 2 No Hospital: 1 Inpaties 27. Manner of Death 28a. Date of Injur		t 3 DOA Oth	4 Nursing Home	9 5 Residence		fy)
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Division	Atten r deal octor: by the	fica	3 Suicide 6 Could not be 28e. Place of Inju	ry · At home, farm, stre			If. Location (Street a	and Number or Rur	al Route Number,
ā	s afte	Certification:	4 Homicide determined building, etc.	. (Specify)			City or Town, Sta	te)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier (Check only one) Certifier Description Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	occurred at the ting restigation, in my o	ne, date and plane, an pinion, death occurred	d dies to the obuse(I at the time, date a	s) and marmar as a nd place, and due t	utted. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. D	ate signed (Month,	Day, Year)
	(.)		Shuser MD.		Re	2 0000	0 18)-21-	2005
	141		30. Name and voriess of person who completed cause of de	eath (Item 23a) (Type, I	Print)	0000		, 01	6000
	6		31. Date filed (Month, Day, Year) 22. Registra	2000 FO	Acklin 3	Surre Or	we Balty	myre M	221237
10 m	Sta Registr		30. Name and weress of person who completed cause of de San Harmon (Month, Day, Year) 31. Date filed (Month, Day, Year) OCT 2 4 2005	r's Signature					

State of Marvland / Department of Health and Mental Hygiene o o

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September 28, 2005

			1 - For State Registrar	Otate of Maryla	Сел	rtificate of l	Death		"ZUU5	34195
	Physici /Medi		1. Decedent's Name (First, Middle, La David	st) Keith	Alton,	Jr.		2. Date of Death		3. Time of Death 05 1740 PM
)	Examir		4a. Facility Name (If not institution, giv 300 Block Route			4b. City, Town, or Harwood	Location of Death		4c. County of Dea	
	Funeral Director		213-00-09/9	6ex 7. Age (In yr 1 XM 2 F 31	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Jan. 13,		thplace (State or Foreigr ountry) ryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show say injury or other traumatic event, the Madical Examinational Deports and Once.	rector	Usual Residence of Decedent 10a. State 10b. County MD Anne At 10e. Street and Number 10b. County Anne At 10e. Street and Number 10b. County 10b. Cou		City, Town or Lo			100	g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes ঽ\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	sath with s 23a or	Funeral Director	99 Marylou Drive	10 111 - 0 - 1 - 1 - 5	110	20	0711		U	SA
980	ours after de rai', or item Exeminar	þ	11. Marital Status XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🗓 No	spanic Origin? (Spen, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
1215-0	within 72 ho ne. .hen "natur ie Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-4or 5+)	(Give	DO NOT use retired	luring most of working	16	6b. Kind of Business	/Industry
and 5	d be filed v entat Hygie ced other t c event, th	Be	17. Father's Name (First, Middle, Last, David K. Alton, S		Self	Employed	18. Mother's Name			
Baltimore, Maryland 21215-0036	nd 2 shoul lth and Me 27 is mark r traumati	P P	19a. Informant's Name/Relationship (Robin S. Cain (Mo	Type, Print)			Robin S.	Route Number, (City or Town, State,	Zip Code)
imore,	Pages 1 ar nent of Hea ant: if item ary or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	20b. Removal from State	. Place of Dispo	sition (Name of natory or other place	rive, Loth	ate 20	20/11 Oc. Location - City or altimore,	
Balt	permit. Depertr Importe eny inju		21. Signature of Funeral Service Lice	fr-		IZ Kidge.	s of Facility Funeral H Ly Avenue,	Home, P.A.	A. lis. MD 2	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the de one cause on each line. a	ple	er the mode of dying	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a conse	aquence of).					
68760,	ntificate be executed ing physicien and a as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a conse	equence of):					
.O. Box	the death ce y the attendii ched for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ords, P	The law requires thet ste has been signed b page 2 should be deta	۵	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause give	n in Part I.			o the cause of death?
Vital Record		Completed			-			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
	Physician: The riths certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	26. Place of Death		ce 6 ⊠Other (Spe	
Division of	ding h. After funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 9/27/05		28c. Injury Work	at ? es 2 No	Bd. Describe how	injury occurred	relieble
<u>></u>	Hospitel or Atten 4 hours after deet Funeral Director: 1ely filled in by the		4 Homicide determined	building, etc. (Spec	road			Bf. Location (Stree City or Town, S	et and Number or R State) 300 61 D, MD	ural Route Number & 12+ 408
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Examone)	ysicien: To the best of my kinner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	estigation, in my op	inion, death occurred	d at the time, date	se(s) and manner as and place, and due Date signed (Mont	to the cause(s)

State Registrar 31. Date filed (Month, Day, Year)

32. Raistrar's Signature

· OCT 0 4 2005

ORIGINAL

O.C.M.E.

f death (Item 23a) (Type. Print) 111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of Mary		artment of H		d Mental Hygi	ene 005	34196
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Vass	3. Time of Death
	/Medic	al	Betty Jane Aisqui					Septemb	er 29, 20	005 7:30 p ^M
	Examin	ėr	4a. Facility Name (If not institution, give s 412 Washington St	,		4b. City, Town, or Annapo		eath	4c. County of De	
F	uneral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24			Arunde1 irthplace (State or Foreign Sountry)
	irector		218-28-2317	M 2∏ F	74 Yrs.	Months Days	Hours N	Nov. 16		aryland
land	M te		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
Man	As-f sh	ctor	MD Anne Art	ınde1	Annapo	lis				1 ∐Yes 2√∑No
ith the	or 28	Director	10e. Street and Number			10f. Zip Code	,	10	g. Citizen of What C	Country?
eath w	18 23a		412 Washington Sti		- i- 11 0	214			USA	
of the diagram	ritem	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No 			ispanic Origin' in, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Arr Black, Wh	
003 ours a	Frair, o	by	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	If Yes, Give Year or Dates:		1□Yes XXNo	Specify:		Specify:	White
15-("natu	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of	working 1	6b. Kind of Busines	s/Industry
with 72	than than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem		1)		O II	
ם ווויים	other vent,	Be C	17. Father's Name (First, Middle, Last)		Homem	akei	18. Mother's	Name (First, Middle, M	Own Home aiden Sumame)	3
aryland 21215-0036 should be filed within 72 hours after death with the Maryland	and Mantar hygens is and water than 23a or 28a-f show as marked other than "natural", or Items 23a or 28a-f show as marked other than Madical Examinating must be multified at	ToE	Joseph F. Dove				Annal	belle Turne	r	
Maryland 21215-0036	nt of Health and Ments :: If item 27 is marked : or other traumatic e		19a. Informant's Name/Relationship (Typ					r Rural Route Number,		
4) E	tem 2 tem 2 other		Peggy A. Lamb (Dat 20a. Method of Disposition	- 2	1403 20b. Place of Dispo	Castlega sition (Name of matory or other place	te Dri	ve, Annapol	.is MD 21 Oc. Location - City o	r Town, State
Page 9	nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	annovan monii otato		natory or other plac t Cemeter				
Baltimore, Dermit. Pages 1 ar	Department of relations of the land injury or of once.		21. Signature of Funeral Service License					al Home, P.	Annapolis	, MD
10 8 6	Ž ≒ % ∂		178- 7. 6			12 Ridge	<u>ly Aver</u>	nue, Annapo	lis, MD 2	
222			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				diac or respiratory arre	st,	Approximate Interval Between Onset and Death
	ysician Iedical		disease or condition resulting in death)	Due to (or s a co		art Fa	ilure			18 years
Ex	aminer		Sequentially list conditions b	200 10 (01 115 2 00	nisequence oi).					
p	sit	iner	Sequentially list conditions, if any, leading to immediate cause first Indexty Cause (Disease or injury	Due to (or as a co	onsequence of):					
xecute	and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	physician and s the burial-transit	dicai E	U d	,	, , .					
ဖြို့ လ	ng ph) a as th	0	IF FEMALE:							
Box	attending for use a	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date of de	Day Year
o g	y the	Physician/M	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	e of death 5	Other (specify)				Day
Records, P.O The law requires that the	been signed by the should be detached	by Pt	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
ord equire	en sig		Chronic Obstruc	tive Pulm	onary Di.	sease		1X Yes	2 □ No 3 □ P	robably 4 Unknown
Record	S C	Completed	Peripheral Vaca	dar Dirense				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	certificate rector, pag			iciency					No 1 □ Ye	s 2 No
Vital	is certificate hi director, page	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	ospital:	2 ER/Outpatien	t 3 DOA Othe		Death (Check only one	ce 6 □Other (Spe	
Division of	n. After thi funeral o	on: T	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of			28d. Describe hov		ecity)
SiO tendii	ector: A ector: A by the fu	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 Y	Yes 2 □ No			
DIVI I or At	Direction by	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
Division of Vita	within 24 hours after deati To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phys	ician: To the best of m	y knowledge, death	occurred at the tim	e, date and pl	ace, and due to the cau	ise(s) and manner a	s stated.
the H	the Fu	Medical	one)	er: On the basis of exa and manner stated.	amination and/or in	vestigation, in my op	oinion, death o	ccurred at the time, dat	e and place, and du	e to the cause(s)
2	To	~2	29b. Signature and title of certifier	(Q) - A	17	29c. License	29193		d. Date signed (Mon	
			30. Name and address of person who cor	noleted cause of death	(Item 23a) (Tuna	Print\			ptember,	10,2005
			Stephen Killian	MD 31	69 Bra	perton St, #	201 , 8	dgewater v	10 2103=	7
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 4 20		Signature	book		J		

			1 - For State Registrar	tate of Maryland		artment of H		nd Men	ntal Hygie	2005	34197
	Physici		1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic	al	June Marie Ashle			# 6% T	.1		ctober	1, 2005	5:15 A M
	Examin	er	4a. Facility Name (If not institution, give stree Northampton Manor	t and number)		4b. City, Town, or Frede		Death		4c. County of De	
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	_If Under 1 Year	If Under 2		Date of Birth (Month, Day, Ye	Frederi	irthplace (State or Foreign
	Director		223-46-5436 1□M	2X) F 74	Yrs.	Months Days	Hours		ril 1,		Country) irginia
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	Maryland Frederick		Fre	derick					1 AYes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code			1 -	Citizen of What	
	s 23a	ral	200 East 16th Street	•			701	1.0.00		Inited S	
10	ter de	Funeral		Vas Decedent Ever in U.S Armed Forces? □ Yes	s. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Orig an, Mexican,	Puerto Rica	Yes or No- an, etc.)	Black, WI	nerican Indian, nite, etc.
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinat must be notified at	þ		f Yes, Give Year or Dates:	•	I□Yes XXNo	Specify:			Specify: W	nite
21215-0036	72 ho natu	Completed	15. Decedent's Education (Specify only highest grade control of th		(Give	lent's Usual Occup	during most	of working	168	. Kind of Busines	ss/Industry
12	within ene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired iemaker	7)			Own Home	
<u>d</u>	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		11011	remaker	18. Mother	's Name (Fi	rst, Middle, Mai		2
<u> a</u>	wuld be Menta arked artic ev	To B	Frank W. Mays				Ru	by Bry	yant Je	rnell	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinating must be notified at ones.		19a. Informant's Name/Relationship (Type,	Print)		g Address (Street:					
	Healt Healt tem 2		Kyle Ashley / Son 20a. Method of Disposition	20b. Pla	ace of Dispo	4 Camden		Date		Location - City	
Baltimore,	Pages ent of nt: If II		1X Burial 2 ☐ Cremation 3 ☐ Remo 3 ☐ Cremation 3 ☐ Crema			natory or other place t Cemete		0/7/20	005 Fr	ederick.	Maryland
alti	Departm Departm Importa any inju		21. Signature of Funeral Service Licensee	71	22	. Name and Addres	ss of Facility	Stauf	fer Fun	eral Hon	ne
<u> </u>	82589		/ourtney	Stauffe7		621 Opos					
	Pnysician		23a. Part1 Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	ons that capsychine death. Levelva Due to (or as a consequence to (or as a c	lascu	lav A	ig, such as o	ardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death min LUCS
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):	maliati	4	77	7		Vene
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of).	neval	17/	ne a			100
	cate be executed obysician and the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
Ő,	oe exe cian ar urial-t	i Ex	resulting in death) Last	Due to (or as a consequent	ence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	d		_						
Box 6	eath certific attending p	_/Me		f yes, outcome of pregnan						23d. Date of c	lelivery
	ne death the atte	icia	in the past 12 months?	1∐Live birth 2∏Fetal o 4∏Pregnant at time of de 9∏Unknown]Ectopic pregnancy] Other (s <i>pecify)</i>				Month	Day Year
P.O.	± ≥ 3	Phys	9 Li Unknown		W	4. 62			OZa Did takan		As the server of death?
of Vital Records,	w requires that been signed b should be deta	by	Part II. Other significant conditions contribu-	uting to death but not resul	lung in the ur	nderlying cause giv	en in Parti.		1 Tes	_	to the cause of death? Probably 4 Unknown
ecc	as b	Completed						_	24a. Was an autopsy	prior to	autopsy findings available completion of cause of
al F	Thate page								performed		es 2 No
₹	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Oth			heck only one) 5 □ Residence	e 6 □Other (Sp	necify)
J Of					28b. Time of Injury				Describe how i		
Sion	Attending r death. ector: After	catic	2 Accident investigation			M 1 🗆	Yes 2□N				
Division	l or Attendater deatl	ertification:	4 Homicide determined 2	 Place of Injury - At hor building, etc. (Specify) 	ne, farm, str	eet, factory, office			City or Town, S		Rural Route Number,
	Hospita 4 hours Funeral ely fillec	edical C	29a. Certifier (Check only one)	in: To the best of my know On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and pinion, death	place, and n occurred a	due to the caus t the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within 2.	Me	29b. Signature and title of certifier			29c. Licens				Date signed (Mo	
)			1			04.	3091		1	10-3-03	
	Q		30. Name and address of person who completed Zar	eted cause of death (Item	23a) (Type,	Print) TOLL	Hou.	se 1	Tre.	Frede	rick MH
	Sta Registr		30. Name and address of person who complete the series of person who compl	32. Registar's Signate	Jr.	Sporte			,		,

			1 - For State Registrar	State of Marylar		artment o		d Mental Hy	/giene Reg. No	- 0 0 0	34198
	Physici		1. Decedent's Name (First, Middle, Last Betsy Ann Albert)		-		2. Date of D Month Oct.		у 2005 ^{Year}	3. Time of Death 8:35 A M
	/Medic Examin		4a. Fecility Name (If not institution, give 30452 Bennett Roa			4b. City, Tow	n, or Location of D			. County of Death	
	Funeral Director		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 24	Hrs. 8. Date of B (Month, D) 8-13-1	irth lay, Year) 934		place (State or Foreign intry) USA
	Maryland -f ahow	tor	Usual Residence of Decedent 10a. State 10b. County Md. Wicomi		ty, Town or Lo						10d. Inside Cily Limits 1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Number			10f. Zip Cod				tizen of What Cou	intry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itams 23s or 28s-1 show aumatic avant. The Madical Examiner must be notified at	by Funeral	30452 Bennett Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	d 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 図No If Yes, Give Year or Dates:				? (Specify Yes or N uerto Rican, etc.)		USA 14. Race - Ameri Black, White, Specify: Wh:	
21215-0036	within 72 ho ene. then "netur he Medical i	Completed	15. Decedent's Edu (Specify only highest grad		(Give life. i	dent's Usual Oc kind of work do DO NOT use re tary Ai	ne during most of tired)	working		ind of Business/Ir ursing H	,
ind 2	ed ital	Be	17. Father's Name (First, Middle, Last)		Dic	cary Ar	18. Mother's	Name (First, Middle	, Maiden		
Maryland	should be and Mental marked o	T _o	Granville Frankli 19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Str		Larrimor		or Town, State, Zij	o Code)
	1 and Health Iem 27 other tr		Nancy L. Leggs,	206. 1	aw- 29		ngneck Pl	Lace, Sal	isbuı 20c. La	ry, Md. 2	21804
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licens		00 22		ldress of Facility uneral Ho	. 8,2005 ome, Inc. rel, De.			
	Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, or comp shock, or heart tailure. List only o Immediate Cause (Final disease or condition resulting in death) St. wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ications that caused the deane cause on each line. a. Due to (or as a consect to the consect to	th. Do not ent		dying, such as car		arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the second side has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a consect	quence of):						
.O. Box	at the death certific by the attending p tached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3□	Ectopic pregna Other (specify				23d. Date of delive Month	ery Day Year
rds, P	quires that an signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause	given in Part I.		tobacco u Yes 2		he cause of death?
Il Records,		Completed								prior to co death?	opsy findings available impletion of cause of
Vita	Physician: The ribis certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	150/0		Other	Death (Check only			
Division of Vital	Ing After une	-	27. Manner of Death 1. Annual 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. li	4 □ Nursin njury at Work? i □ Yes 2 □ No	ng Home 5 ARes 28d. Describe			y)
Divis	7 5 E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy) 			City or To	wn, State		
	To the Hospital of within 24 hours at To the Funeral D Completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the restigation, in m	e time, date and piny opinion, death o	lace, and due to the occurred at the time	cause(s) date and	and manner as s d place, and due to	tated. o the cause(s)
)	To th To th comp	Me	29b. Signature and title of certifier	· Ca		100	ense number	2		te signed (Month,	
	18		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	Print)	col 4	7 mn	218		005
Ì	Sta Registr	te ar	30. Name and address of person who control of the c	32. Registrar's Signature 1005	ature	backs				•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items /, 8 per fh g864 2-21-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6:30 PM Physician 15 2005 SAKINA OCTOBER AHMED /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNIV. OF MARYLAND MED. SYSTEMS BALTIMORE If Under 1 Year If Under 24 Hrs.
Months DS Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Gar) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Months Director October 7, 2005 none Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b County 10d. Inside City Limits traumatic event, the Medical Exeminer must be notified at Gaithersburg Montgomery 1 Yes 2 No Maryland Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 20879 18343 Hallmark Court Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none baby 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental F is marked of Rubab Ahmed Syed Riaz Ahmed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 18343 Hallmark Court Gaithersburg, Maryland20879 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 st of Health an / item 27 is Syed Riaz Ahmed -father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD National Memorial Park 10/16/2005 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN **Physician** a MULTIPLE INFARCTS /Medical Due to (or as a consequence of): Examiner PREMATURIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit SUSPECT THROMBOPHILIA resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 TYes After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Other: Unpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending s after death.
If Director: Aft
id in by the fun 1 Yes 2 No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a
To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. ö

certificate has

the Maryland

hours after

Baltimore, Maryland 21215-0036

28a-1 show

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Itema 23a

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"natural"

al Hygiene.

State «Registrar 29b. Signapare

31. Date filed (Month, Day.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. A. I I MUKER, AN, MD 22 SCHIT Greene St, Baltimore, Md 21201 32. Registrar's Signature

DHMH 17 Rev 1/2001

D000 43985

29d. Date signed (Month, Day, Year)

OCTOBER, 15, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 5:50 A M ELIZABETH ANDREW 10 16 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 2/22/1922 5. Social Security Number 7. Age (In yrs. last birthday) 6 Say 9. Birthplace (State or Foreign **Funeral** 1 M 28 F 570-58-6090 Germany Director 83 Usuel Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Meurical Examinar must be notified at Aberdeen Director Maryland Harford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1121 Old Philadelphia Rd, #51 21001 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Experiment once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Specify: White þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christina Sperling Karl Sperling 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Golladay (Grandson) 303 S. Washington St. Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State Harford Mem. Gdns. 10/19/05 Aberdeen, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titlated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cau 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After To the Hospital or Attanding 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D3228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15

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			1 - State Registrar	Otato of Mic	Cei	tificate of D			g. No.	34201
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	Funeral		5. Social Security Number 6. Se	7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director		244-30-6837	☑M 2□F	57 Yrs.	Working Day's	Tiodis IVIIII.	Sept. 12		rginia
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	sho	'n			TOC. City, TOWN OF LO	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	with t	급		. 10	•	10f. Zip Code		10	g. Citizen of What Co	
	ss 23	Funeral Directo	1338 Taney Avenue			217		and Van an Na	Unit	ed States
	Item Item	Ę.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent if Armed Forces? 1 ☐ Yes 2 ☑ N		Was Decedent of His f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, Whit	
336	72 hours after death with the Maryland Insturel', or Items 23s or 28s-f show Jical Exantret must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		∏ Yes 2√√ No	Specify:		Specify: B	lack
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<u> a</u>	Ment Ment arkec	To I	Joseph Bembury				Elizab	eth (uno	btainable))
Maryland 21215-0036	2 sho and Is mu		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street ar	nd Number or Rura	al Route Number,	City or Town, State, 2	Zip Code)
≥	and ealth n 27 nar tr		Anna Bembury / Wi	fe			., Apt.	101; Fre	derick, M	D 21702
ore	of H of H if iten		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place		per 8,	Dc. Location - City or	Town, State
Ē	ment tant: jury		' 4 ☐ Donation 5 ☐ Other (Specify)	Greenmoun		ry 200)5 Ba	altimore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Medical Exp. injury or other traumatic event, It a Medical Exp. injury or other traumatic event, It a Medical Exp. injury or other profiled at ODGs.		21. Signature of Funeral Service Licens	600	Re 95	Name and Address Sthaven F	of Facility uneral S	ervices,	Skkot Coo derick, M	dy P.A.
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Division of	or At after of Direction by	Certification;	4 Homicide determined	building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office	4	City or Town,	et and Number or Ru State)	iral Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination and/or inv	estigation, in my opin	nion, death occurre	end due to the cau ed at the time, date	se(s) and manner as and place, and due	to the cause(s)
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	1		30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type, F	Print) Kan	an H	dhud	ino	
			30. Name and address of person who co	5 John	for Bring	e Fre	dench	c, NO	2170	02
	Sta Registr	te	31. Date filed (Month, Day, Year) OCT 1 1	2005 32. Resistra	r's Signature	books				

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Physicia /Medica Examine	al er	WALTER PRICE 1 4a. Facility Name (If not institution, give Upper Chesapeake Medi	ve street and number)		4b. City, Town, or Bel Air		ath		Year 2005 County of Death Harfor	12:52P
uneral irector			Sex 7. Age (In	yrs. last birthday) Yrs.	Months Days	If Under 24 Hi Hours Mi		irth 197, <i>Year)</i> 1931	9. Birth Cou Mary	place (State or Fo intry) 'Land
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127 is m er traum		19a. Informant's Name/Relationship (Rose Farley/Si		19b. Mailir 320 6	ng Address <i>(Street a</i> Copenhav e	and Number or F er Road	Rural Route Numb , Street	er, City o	or Town, State, Zi _l 21154	o Code)
ant: If Item ary or oth		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ 4 □ Donation 5 □ Other (Specif. 21. Sign 1 = 1 Furgeral Service Lice	Removal from State (fy)	ob. Place of Dispo cemetery, cred Evans Eag	matory or other place gle Crema	tory 10,	Date /19/200 5 1		ocation - City or T	own, State
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Bush, Walter

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	Physic	an	1. Decedent's Name (First, Middle	e, Last)	-						2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medi		ETHEL LOUISE PI								OCTOBER		2005	8:00 A M
	Examir	ner	4a. Fecility Name (If not institution	-	er)				Location of				ty of Death	
			FORT WASHINGTON 5. Social Security Number		Age (In yrs.	last hirthday)	FORT If Under		HINGT If Under		C Date of Birth		CE GE	
	Funeral Director		240-14-0020	1 M 2 F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day AUGUST 18	Year)	9. Birthp	place (State or Foreign http) CAROLINA
			Usual Residence of Decedent								7100001 IV	, 1)11	INACIII	Christin
	arylar show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits
	h tha Marylan r 280-f ehow	cto	MARYLAND CHAR	LES	BRY	ANS RO								1 ☐ Yes 2 ☐ No
	72 hours after death with the Maryland neture!', or Iteme 23e or 28e-1 show lical Examination notified at	Funeral Directo	10e. Street and Number 7050 DADDY S PL	ACE			10f. Zip					l0g. Citizen o		
	eath w	era	11. Marital Status	ACE 12. Was Decede	nt Ever in II	C 12 1		0616		-i-2 /C-		UNITED		
	Itar dea	F	1 ☐ Never Married 2 [X]Marri	Armed Force	es?	.3.	f Yes, spec	fy Cubai	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,	
8	urs aft	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			I□Yes 2	2 □ X No	Specify:			Spec	ity:	LACK
5-0036	72 hours after death with "neturel", or iteme 23e or olical Examinar must be	Completed	15. Decedent (Specify only highes			16a. Deced	lent's Usua	Occupa	tion	of work	na	16b. Kind of		
2	c * 4	d d	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of wor DO NDT us			OF WORK	ng			
121	filad w Hyglar sther ti		10TH GRADE	()		FOST	ER MO	-			15 1		CARE	
Maryland	s 1 and 2 should ba fillad withir f Health and Mantal Hyglana. Item 27 le marked other then other treumetic event, the Ma	Be	17. Father's Name (First, Middle, WILLIAM PITT	Last)				- 1			(First, Middle, RNEY PIT		ıme)	
Z	should nd Ma mark metic	၉	19a, Informant's Name/Relationsh	nio (Tvoe. Print)		19b Mailin	n Address				I Route Number		State 7in	Codol
S	and 2 salth ar 27 le		CHARLES O. BLAN		N/ POA						ANS ROA			
6	of Hea		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	e of	I		-	20c. Location		
Ę	Paga anto nt: If		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St			emetery, cren DONTA B				CTOBE	R 10.2005	BRYANS	S ROAD	,MARYLAND
Baltimore,	permit. Pagas Dapartmant of I Importent: If Its eny injury or of	H	21. See Jure of Funeral Service	- 0							ME, P.A		J ROM	, initiant
8	Dapa Impo eny li		LADIA C. THORNT	ON JOHNSON M	00583	3,	10KN 10 439 L	IVIN	UNEKA GSTON	L HU	ME, P.A D. TNDT	AN HEA	D MAT	RYLAND 20640
8760,	Late be exacuted whysician and whysician and the burial-transit	al Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or c.	as a consequal as a consequence as a consequen	uence of): 3 Le uence ory:	,				10 Vac		wi.	Interval Between Onset and Death
O. Box 6	Tha law raquiras that tha daath cartlicata ba exacutad tta has baan signed by tha attanding physician and baga 2 should ba datachad tor use as tha burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 ☐ Fetal t at time of de	death 3	Ectopic pre Other (spe	gnancy cify)					ate of delive	ry Day Year
Vital Records, P.	w raquiras that baan signed b should ba datt	þ	Part II. Other significant condition	ns contributing to death	h but not resu	ulting in the un	derlying ca	use give	n in Part I.			oacco use cor		e cause of death? ably 4 □Unknown
တ္ထ	law raqu as baan 2 shoul	Completed									24a. Was a	n 24b.	Were autop	osy findings available
Ä	Tha la	E									autops perform 1 Yes 2	ned?	death?	npletion of cause of
ita	cartifical ractor, p	BeC	25. Was case referred to medical examiner?			-			26. Place	of Death	(Check only on			20110
of V	Physicien: rthis cartific ral diractor,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Thips		ER/Outpatient	3 🗆 DQ	Other	t 4□ Nur	sing Hon	ne 5□Reside	nce 6 □Oti	ner (Specify,)
Ē		ë ë	27. Mann of Death 1 Natural 5 ☐ Pending		njury Day Year)	28b. Time of Injury		c. Injury Work?			8d. Describe ho	w injury occu	rred	
Sic	Attending ir daath. ector: Afta by tha funa	cat	2 Accident investigation 3 Suicide 6 Could n	ot bo	tel and		М		es 2.©4¶	-				
Division	or A attar Direc	Certification;	4 ☐ Homicide determin	28e. Place of building,	etc. (Specify	me, rarm, stre	et, factory,	office		2	8f. Location (Sti City or Town	eet and Num , State)	ber or Rumai	Route Number,
_	ours ours nerel		29a. Certifier 1/F Certifying	Physicien: To the be	st of my know	wledge death	occurred a	t the time	date and	I place, a	nd due to the ca	use/s) and m	25525 25 25	atod.
	the Hospital	Medical	(Check only 2 Medical E	xeminer: On the basis and manner	of examinati	ion and/or inv	estigation, i	n my opi	nion, death	occurre	d at the time, da	ite and place,	and due to	the cause(s)
	To the Hospital or Attent within 24 hours attar death To the Funeral Director: complately filled in by the	M	29b. Signature and title of certifier	1			29c.	License	number		29	d. Date signe	d (Month, D	Day, Year)
			X	Cry	7-	- Sim Sin.						10	15	125.
(DB1		30. Name and address of person w	1URTHY	MI)	6196	0)	(0)	JHZ	LL M	RAD	# 5	20	
*	Sta Registr		31. Date filed (Month, Day, Year)	7 2005 32. R	strar's Signat	ure 14	porte	0						

James Burd 05-06704 NJM

		1	19b 1- State AMEND#10E PER FH Registrar 10/6/05 AACO	State of Mar		ertificate of			giene, Rog. No.	71115	342	04
	Physicia		Decedent's Name (First, Middle, Las James E. Burd					2. Date of De Month October	Day	2ŎÖ5	3. Time of D	eath M
	/Medic Examin		4a. Facility Name (If not institution, give Anne Arundel Med			4b. City, Town, o		ath		County of Death		
	Funeral Director		165-46-4737	7. Age (i 2 M 2 □ F	In yrs. last birthday 51 Yrs.	Months Days	If Under 24 H Hours Mi		y, Year)		place (State or F intry) nsylvan:	
death with the Maryland	ied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru		0c. City, Town or l						10d. Inside City 1 ☐ Yes 2	
with the	3a or 28a it be noti	i Direc	10e. Street and Number 2707 Summer View W			10f. Zip Code 21401				ted Sta		
	ral', or iteme 2 Examinar mus	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🙀 No		(Specify Yes or No erto Rican, etc.)		4. Race - Amer Black, White Specify: whi	, etc.	
within 72 hours after	ne. han "natul a Madical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire val Offic	during most of w d)	varking		nd of Business/I	ndustry	
	ental Hygie ked other t ic event, III	To Be Co	17. Father's Name (First, Middle, Last) Ronald Burd	5 +	l Na	var offic	18. Mother's N	lame (First, Middle etta Hilb	, Maiden	. Navy Sumame)		
ore, mary	feelth om 27 ther tr	-	19a. Informant's Name/Relationship (1) Nancy Burd/ wife 20a. Method of Disposition 1 □ Burial 2 【Coremation 3 □		2707 20b. Place of Disp	Summer V cosition (Name of ematory or other pla	iew Way	#371 Ann	apol 2 c. Lo	is MD cation · City or 1	21/401 Town, State	
Dailimore	Department of the importent: if ite eny injury or of once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen)	,	e Cremato 22. Name and Addre 47 Duke o	ess of Facility		ay1o	r Funer	al Home,	, Inc
te be executed	ys 9	dical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	Leso he consequence of):	nter the mode of dyi			rrest,		Approximate Interval Betwe Onset and De	een
The law requires thet the death certifical	y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		2	3d. Date of deli Month	very Day Ye	ar
quires thet	n signed b	Ď	Part II. Other significant conditions of	ontributing to death but in	not resulting in the	underlying cause gr	ven in Part I.		tobacco u Yes 2	2	the cause of dea	
The law requ	ate has page 2	Completed						24a. Was auto perfo 1 Yes	psy ormed?	24b. Were aut prior to death?	topsy findings av ompletion of cau 2 \(\text{No} \)	/ailable use of
VISION OF VICAL Attending Physician:	death. stor: After this certificate the funeral director, pag	Certification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		(ear) 28b. Time Injury	of 28c. Inju Wo M 1	ner: 4 🗆 Nursing	Death Check only of Home 5 Resi	idence 6 how injury	occurred ,	nfy) rai Route Numbe	er.
VIV	hours after merel Direc y filled in by		4 Homicide determined 29a. Certifier 1 Certifying Ph	building, etc. ((Specify) my knowledge, dea	ath occurred at the ti		City or To	wn, State)	and manner as	stated.	
To the Ho	within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	Medical	29b. Signature and title of certifier	niner: On the basis of each manner state	up	29c. Liceo	se number		29d. Date	ber, 2,	2005	01
	Sta Registr		30. Name and address of person who a subject of the	32. Registrars	Signature	e, Print) 111 Po	enn Stre	eet Balt:	imore	e, Maryl	and 212	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Jeannette Banker September 26 2005 2035 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year April 13) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Year) 1919 Pennsylvania 1 □ M 2XX 86 Yrs. Director 197-10-5607 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. sont: If item 27 Is marked other than "naturel; or Items 23e or 28e-f show 10a. State f Health and Mental Hygene. item 27 is marked other than "naturel", or items 23e or 28e-f show other treumatic event, if a Mydical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2**X** No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Crisfield Way 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ★XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 XWidowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles W. Thompson, Jr. Marion White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope Caravelli (Daughter) 713 Crisfield Way, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 0 permit. Page Department of Importent: If eny injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9-28-2005 Baltimore, MD 21. Signature of Funeral Service L 22 Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Be Completed 1 🗌 Yes 2 No 3 Probably 4 □Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? a 24a. Was an autopsy performed? Yes 2001 Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. D. le of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif Dimick 29c. License number 29d. Date signed (Menth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lara Dimick, MD 2001 Medical Parkway, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar OCT 0 4 2005

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 2005 34207 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year GEORGE BARNES 12:12 AM OCTOBER 5 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hopkins Hospita Baltinore nder 1 Year I II Under 24 Hrs. If Under 1 Year If Under Hours 5. Social Security Number 212-14-7353 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F 89 Director MD: Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Frederick Md. Frederick Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ST. MADISON 201 VSA 21701 Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: Black 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Frederick City Elementary/Secondary (0-12) College (1-4or 5+) Truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert G. Barnes Smith LARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depurtment of Health a Important: If Item 27 le any njury or othar trai once. 201 Madison St. Apt. 50 Fred. Md. 21701 E. Barnes wite 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem. Gar. Oct. 10, 2005 Fred. Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service LicerSee 22. Name and Address of Facility's Funeral Home Burn 40 West Soum Sr Prederick α 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician RIGHT TUE GANGRENE disease or condition resulting in death) Z WEEKS /Medical Due to (or as a consequence of): Examiner ERIPHERAL VASCULAR DISEASE 3 MONTHS Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by RENAL FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should CHRONIC OBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death? DISEASE 24a. Was an autopsy performed? HYPERTENSION of Vital 1 Yes 1 ☐ Yes 2 No 2 **X**No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \(\text{Homicide} \) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Funs

completely f (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) RES-000 V~ MD OCTOBER 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHETH, GOD NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287 OCT 1 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 34208 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1 0 2005 10:25 PM **Physician** Gwendolvn Baylor 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takona Park Mantgarery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 12-05-1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1□M 21/2 F 577-44-4273 71 Washington DC Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at MD Prince Georges Hyattsville XIX Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2101 Lewisdale Drive 20783 USA 238 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or Items 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Madical Examinar 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: USA 3 Widowed 4 XX ivorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation during most of working (Give kind of work done di life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Herman Morris Baylor, Sr. Geraldine Amelia MAson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane James Daughter 2101 Lewisdale Drive, Hyattsville, MD 29783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/6/05 Brentwood MD 22. Name and Address of Facility 21. Signature of Funeral Se ice Licensee MIX Bianchi 814 Upshur St NW Washington. DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SHOCK Physician resulting in death) /Medical Due to (or as a consequence of): ARRHYTHMIA Examiner ARD/ AC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trans RESPIRATORY FAILURE Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) TYPS 2 NO 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has all director, page 2 2 No 1 🗆 Yes 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: ۵ 1 ☐ Yes 2 I No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD52855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANKVER PKUN, GREENBAT, 40 20170 CHANGIA DAII 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 0 7 2005 Registrar

DHMH 17 Rev 1/2001

Lori Collins 05-06987

)5–(:rn)6987		Unpend item/2.	Ba. 27, perM	E, G848 , 10/2	26/05 TT	. Ensure A	Mental Hyd	are Legible.	
-T11			1 - State Registrar	State of W		rtificate of			I S NO D D C	01000
	W. 40		1. Decedent's Name (First, Middle, La	ast)			-	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		LORI I	BIXLER	COLLINS			October	14, 2005	12:35 P M
	Examir	ier	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Death	1	4c. County of Dea	th
	*	a di	Peninsula Region			Salish	Oury If Under 24 Hrs.	O. Data of Birth	Wicomi	
3	Funeral Director			Sex 7. Ag 1 ☐ M 2 🔀 F	je (In yrs. last birthday) 34 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, APRIL 14	Year) Co	thplace (State or Foreign buntry) ELAWARE
0	_		Usual Residence of Decedent		<u> </u>			AIKID 14	, 17/1 D	LLAWARE
	ehow	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f-	cto	MARYLAND WICOMI	CO	PITTSVI	LLE				1 XYes 2 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code		10	og, Citizen of What Co	ountry?
	e 23s	srai	7466 COLLINS S	TREET 12. Was Decedent	Ever in 11 C 12	21850	lianneia Osinia? (Os		USA	riana Indian
	ter de	Š	11. Marital Status 1 □ Never Married 2 Married	Armed Forces?		If Yes, specify Cubi	fispanic Origin? (Si an, Mexican, Puert	Rican, etc.)	14. Race - Ame Black, Whit	
036	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	WHITE
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow disal Examinat must be notified at	Completed	15. Decedent's 8 (Specify only highest gi		16a. Dece	dent's Usual Occup	nation during most of wor	kina	6b. Kind of Business	Industry
21	within iene. than	mple	Elementary/Secondary (0-12)	College (1-4or	D+) !		during most of world)	in g		_
	filed w Hygie ther ti		17. Father's Name (First, Middle, Las	4	P	ARALEGAL	18 Mather's Nam	ne (First, Middle, M	HOSPITA	<u>L</u>
and	buld be f Mental It arked of atic eve	Be	STEPHEN	CURTIS	BIXLER		MARY	HARV		
Maryland	2 should and Men le marke aumatic	ပ	19a. Informant's Name/Relationship			ng Address (Street			City or Town, State, 2	Zio Code)
Ma	tra tra		KEVIN P. COLLINS						LE, MARYLA	
Je,	of Heal of Heal if Item 2 or other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	cel	Date 2	Oc. Location - City or	Town, State
Ē	Page nent c Int: If		1 ABurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci			CEMETERY	10/2	0/05 V	VHALEYVILL:	E, MARYLAND
Baltimore,	permit. Pag Department Important: I any injury o		21. Sig / tu a of uner a Servica Liv	5836	22	2. Name and Addre	ss of Facility			
	20 E # 9		Marker WE	tant					BYVILLE, D	E. 19975
	Physician /Medical Examiner ponial-transit	cal Examiner	23a. Part f. Enter the disease, or conshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atheroso Due to (or as b. Due to (or as c.	a consequence of): a consequence of):					Interval Between Onset and Death
P.O. Box 687	t the death certifical by the attending phy ached for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	4□Pregnant at 9□ Unknown	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
ds,	ires tha signed d be det	l by	Part II. Other significant conditions	contributing to death o	at not resulting in the u	nderlying cause giv	en in Parti.	1 \(\text{Yes}	acco use contribute to s 2 No 3 □ Pri	othe cause of death?
Ö	w require been si	etec								•
of Vital Records,	: The lav	Completed						24a. Was an autopsy perform	prior 16	topsy findings available completion of cause of
Vita	Physician: The r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		t 20 DOA Oth	05	th (Check only one		
o	Phys r this ral dii	. To	1 XYes 2 No 27. Manner of Death	1 ☐ Inpatie		1 3L DOX	4 Nursing ric	ome 5 Resider 28d. Describe hove	nce 6 Other (Spec	oify)
Division	th. th. : After funer	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	Wor	k? Yes 2 □ No		injary occurred	
Visi	Atter	ifica	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of inj	ury - At home, farm, str	eet, factory, office			eet and Number or Ru	ral Route Number,
Ö	s after or all Dir	Certification:	4 Difficial	building, et	c. (Specify)			City or Town,	State)	
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Madical Exa	hysician: To the best miner: On the basis of and manner sta	of my knowledge, death f examination and/or in ated.	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the Comp	Ň	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Month	n, Day, Year)
)			Margine !	fre Grel	eim	0	.C.M.E.	0	ctober 15,	2005
			30. Name and address of person who MAVGAMM	completed cause of d		Print)			and 21201	
the sale	Sta	te	31. Date filed (Month, Day, Year)	32. Pojistra	ar's Signature					
will the state of	Registr	ar	OCT 2'0	ZUUD SENE	w & B	sale				

DHMH 17 Rev 1/2001

		State of Maryland / 1- State Amend #26 per fh 10/11/05 of	Depa	rtment of Health and tificate of Death		gien 2 0 0 5	34210
		Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
Physici /Medio		GLENDA BYRNES CROWLEY			oCT.	6 20°0	5 2:10 PM
Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat	h	4c. County of De	
Funeral		HOMEWOOD AT CRUMLAND FARMS 5. Social Security Number 6. Sex 7 7. Age (In yrs. last b	irthday)	FREDERICK If Under 1 Year If Under 24 Hrs	8. Date of Birt	FREDE	RICK irthplace (State or Foreign
Director		579-36-3172 1□M 2♥F 74	Yrs.	Months Days Hours Min.	FEB 2	6 1931	FL
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Loc	eation			10d. Inside City Limits
Marylan f show	ro			SVILLE			1 Yes 2 No
ith the M or 28a-f	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What (Country?
23a c		18010 BARNESVILLE ROAD		20838		USA	
ified within 72 hours after death with the Maryland Hygiene. Hygiene thysical controls on 1888-18 show onto the Majoral Eraninst court be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decadent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	Black, Wh	
72 hours "naturel",	ted	15. Decedent's Education 16a (Specify only highest grade completed)	a. Deced	ent's Usual Occupation kind of work done during most of wo	rking	16b. Kind of Busines	s/industry
d within 72 ho gione. ir then "natu	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	ONOT use retired)	Ning .	DOMECE:	T.C.
be filed vital Hygie dother t		12	1005		ne (First, Middle,	DOMEST:	LC
e d fa	To Be	FRANCIS THRALLS		MYRTLE	- 1		
inal yearloo 2.12. 4.2 should be filed within th and Mental Hygiene. 7 is marked other then traumatic event, the M				g Address (Street and Number or Ru			
and land lealth mm 27 her tr				7 GENERAL CUST			
permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other tra		1 ☑Burial 2 ☐Cremation 3 ☐Removal from State cemete	ery, crem	atory or other place)	Date	20c. Location - City of	
mit. Poartme		`4 □ Donation 5 □ Other (Specify) NATIO 21. Signature of Fuperal Sprvice Lipensee	22.	MEMORIAL 10/		FALLS CI	HURCH, VA
Pagin Pag		MD Del	HP	ILTON FUNERÁL .O. BOX 86, BA	HOME RNESVI	LLE, MD	20838
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate Interval Between
Physician				tour Schoosis			Onset and Death
/Medical Examiner		Due to (or as a consequence Prevence to b.	∍ of):				2 1111 6
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):				2 weaks
acuted ind transi	Examiner	that initiated events c.					1 year.
cate be executed by sician and the burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence	e of):				
ficate physics the	edicai	d					
The law requires that the death certific the law requires that the death certific ten has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat		Ectopic pregnancy		23d. Date of do	elivery Day Year
that the de ed by the a detached f	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 📙	Other (specify)			-4,
signed b	by Pł	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
w require been sig should b		HTN			1 🗆 Y	es 2□No 3□F	robably 4 Denknown
a law r has be e 2 sh	Completed				24a. Was a autop	sy prior to	utopsy findings available completion of cause of
	- 1					2 ₽ No 1□Ye	s 2 No
ysician: nis certifica director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Thipatient 2 ☐ ER/O	utaatioat	Other	ath (Check only or	ne) ence 6 □Other (Sp	
ਰ ≐ ਜ਼	H	27. Manner of Death 28a. Date of Injury 28b.	Time of Injury	28c. Injury at Work?		ow injury occurred	эспу)
endin eath. or: All	atio	2 Accident investigation	,ury	M 1 Yes 2 No			
or Att after de Direct in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre	et, factory, office	28f. Location (S City or Tow	treet and Number or F n, State)	Bural Route Number,
spitei lours a nerel I		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death	occurred at the time, date and place	, and due to the c	ause(s) and manner a	s stated.
To the Hospitel or Attending Physicien: within 24 hours alter death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or inv	estigation, in my opinion, death occu	rred at the time, o	late and place, and du	e to the cause(s)
To t To t	Σ	29b. Signature and title of certifier Price. Mcatthe Price.		29c. License number	> 2	29d. Date signed (Mor	
11		, 0		00046249	2	10/6/65	
H		30. Name and address of person who completed cause of death (Item 23a)	(Туре, Р	'rint)	arme c	Merick	110
Sta		31. Date filed (Month, Da) CT 1 1 2005 Register's Signature	C = C	it C'rimianci k	ams, f	IT/IT/ICF	INID

			1- For State of Maryland	/ Department of Health and M Certificate of Death		ene 005 34211
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physic /Medi		Evelyn Cumberland		Month October	Day Year 5:20 a.M
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
			Mallard Bay Care Center	Cambridge t birthday) If Under 1 Year If Under 24 Hrs.	T	Dorchester
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 1 M 254 F 77	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	
			Usual Residence of Decedent		April 15	5, 1928 Maryland
6	anylan show	_	10a. State 10b. County 10c. City, 1 MD Dorchester	Town or Location		10d. Inside City Limits
Y	ith the Marylar or 28e-f show	ecto		Cambridge		1 ⊠ Yes 2 □ No
\mathcal{Z}		Funeral Director	10e. Street and Number 520 Glenburn Avenue	10f. Zip Code	10	g. Citizen of What Country?
Z	ours after death wirel; or items 23a	era	11. Marital Status 12. Was Decedent Ever in U.S.	21613	pecify Yes or No-	USA 14. Race - American Indian,
9	after dea or items	F.	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
003	"naturel", o	d by	3 Nation 3	1 ☐ Yes 2 🗷 No Specify:		Specify: white
15-	"nati	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 1	6b. Kind of Business/Industry
12	withi iene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) unknown	homemaker		own home
þ	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental the Mental than th	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M.	
/lar	should be ind Menta marked	To E	William Bowers	Georg:	ia Conrad	l
Maryland 21215-0036	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 Is marked other than 'natu other traumatic event, the McGcal			19b. Mailing Address (Street and Number or Rur		
	permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any injury or other trau once.		Ken Kramer son	4700 Water Park Drive		
Baltimore,	ages in of h		1 Burial 2 Cremation 3 Removal from State	etery, crematory or other place)		Oc. Location - City or Town, State
語	artmer artmer ortant injury		' 4 ☐ Donation 5 ☐ Other (Specify) Sali 21. Signature of Funeral Service Licensee	.sbury Crematory 10/7		Salisbury, MD
Ba	permit. Departr Importa any inju		Ro LB	11		eral Home P.A.
			23a. Part1. Enter the disease, or complications that caused the death.	700 Locust St., Ca		st, Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Motostic 1	n	Interval Between Onset and Death
	/Medical		resulting in death) a. Due to or as a consequen	ice of):	PAICIE	iona Iyear
-0	Examiner		Sequentially list conditions, b. 6 95+6	Metastatic (ice of): Cancer		/
	pe tis	Examiner	f ary, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of).		
	executed n and ial-transit	хаш	that initiated events resulting in death) Last C. Due to (or as a consequent)	ce of):		
8760,	be icie	cai E		30 31/1		,
687		70	d			
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 1 □ Live birth 2 □ Fetal de			23d. Date of delivery
	the atth	sicia	1 Yes 2 No 4 Pregnant at time of death			Month Day Year
P.0	that the displaying the detached	Phy	9 Unknown			
S,	law requires that the death certific as been signed by the attending f 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting	og in the underlying cause given in Part I. Ohe Sema Concesti	23e. Did toba	cco use contribute to the cause of death?
Ö	w requ	etec	DIBOAT PISORE! CAN	-11 1 11 0 u		2 No 3 Probably 4 Unknown
Records,	0 5 0	Completed by	HEART 19.1418, 971, 91 1.15	1.1194,00 Hypothyco	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Vital		e Co	25. Was care referred to medical	77 7	1□ Yes 2	1 Li Yes 2 Lives
∑.	S S	To B	examiner? Hospital:	Other	h Check only one)	ce 6 ☐Other (Specify)
J Of		L:u	27. Manner of Death 28a. Date of Injury 28		28d. Describe how	
Sio	Attending r death. sctor: After by the fune	atic	2 ☐ Accident investigation	M 1 Yes 2 No		
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	Hospitel of the policy of the		29a. Certifier 1 Pertifying Physician: To the best of my knowled	11		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) (Check only one)	1ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)
			of allen 1.	0. H446,15		10/6/05
			30. Name and address of person who completed cause of death (Item 23	a) (Type, Print)	alte.	1900
			Lois / A Nore/ D.O. 100	Bramble St	(9 0	abridge MD
U	Sta Registr	re.	31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 11 2005	& Sports		V

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Marietta Kathleen Bines Carrick 1700 October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F 216-20-0584 80 Yrs 14,1925 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Maryland Cecil Perryville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Franklin Street 21903 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: δ White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Eleven Years Homemaker and Mental Hygie Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic event, page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame William Thomas Bines, Sr. Ethel Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Gilbert Road, Aberdeen, Maryland Kathy M. Plummer (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Harford Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 10/12/05 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. MENTER Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma Lima Physician 6 WKE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 K Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death

To the Funerel Director: /
completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Du cur 32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kannedin Milham with 1106 Revolution St Havrete aremend 21076 31. Date filed (Month Day registrar's Signature State Registra

amend #10b&19b Per Int G887 in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year ONNER SEPTEMBER 29 7.41 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner GLEN BURNIE BALTIMORE WASHINGTONN ENTER NNEARUNDEL 8. Date of Birth (Month, Day, Year)
Sept. 22,1934 If Under 1 Year | If Under 24 Hrs. **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Months Days Hours 1X M 2□ F 411-50-3380 Yrs. Director 71 Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits truest he richtliged at Odenton Completed by Funeral Director 1 ☐ Yes 2 XNo Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Orchard Overlook, #102 21054 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or other traumatic avent, the Medical Examinar Black, White, etc. 1XX es 2 □ No If Yes, Give Year or Dates: 1956-61 1 Never Married 2000 Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenf's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ James Earl Conner Hazel Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 700 Orchard Overlook, #102, Gambrills, MD 21054 Janie I. Conner (Wife) permit. Pages 1 and Department of Healt Important: if Item 2' any injury or other: 2002. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Vet. Cem. 10-3-2005 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. also 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUna Cancer /Medical Due to (or as a consequence of): Examiner Chronic obstructive pulmonan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit neumonia that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 2100 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2. No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

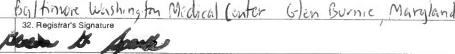
2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier one) 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) OCT 0 4 2005

Koluardo

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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death with the Maryland

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or Attending Physician: The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

			State of Maryland				-	_	
		·	1- For State State Registrar	-	tificate of D		Reg	2005	34214
	Physici	20	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic		Charles H. Christie, Jr.				oct.	4, 2005	12:15p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I		ark	4c. County of Deat	
	Funeral		Genesis ElderCare 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	verna P	8. Date of Birth		Arundel pplace (State or Foreign untry)
	Director		210-20-5528	Yrs.	Months Days	Hours Min.	(Month, Day, 14) Aug. 15	1927	PA
	how	_	10a. State 10b. County 10c. City, T	own or Lo		- Dl-			10d. Inside City Limits
	he Ma	ecto	MD Anne Arundel 10e. Street and Number		Severn	a Park	40	0.00	1 ☐ Yes 2 ☒ No
	3e or 3	by Funeral Director	36 Sunset Drive		10f. Zip Code 211	46	10	g. Citizen <i>o</i> f What Co USA	untry?
	ems 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	perrit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ehow amy njurry or other treumatic event, the Medical Examinat must be rutified at Ance.	by Ft	1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced		☐ Yes 2 TNo	Specify:		Specify:	White
21215-0036	72 ho 'natur	Completed	15. Decedent's Education 1 (Specify only highest grade completed)	(Give	lent's Usual Occupat kind of work done du	ion uring most of work	ing 10	6b. Kind of Business/	ndustry
121	within ane. than	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired) Manage	- 1		Westingho	use
d 2	Hygid other ent, I	Be Co	17. Father's Name (First, Middle, Last)				e (First, Middle, Mi		abe
/lan	uld be Vental Irked	To B	Charles Harrison Christie, Sr.			Doroth	y Fletche	er	
Maryland	2 sho and f is ma							City or Town, State, Z	_
e, N	1 and Health em 27 ther ti		Barbara B. Christie/Wife 20a. Method of Disposition 20b. Place	e of Dispos	unset Dri sition (Name of			MD 2114 Oc. Location - City or	
nor	agas ant of it: If it		1 TRurial 2 Cromation 3 Permoval from State	etery, crem	natory or other place, cans Cemet	Oct	. 7,	Crownsvill	
Baltimore,	pertme portan portan / injur		21. Sofiature Funeral Sylvine Licensee	1		7 2	.005		uneral Home
m	Departing Departing Supported Suppor		Samo Valamei	$\frac{1}{4}$	95 Gov. R	itchie H	wy, Seven	ma Park,	MD 21146
	E 11:		ha. Part I Enter the disease, or complications that caused the death. I shoot, or heart failure. List body one cause on each line. Immeriate Cause (Final						Approximate Interval Between Onset and Death
	Prrysician /Medical	(Immeriate Cause (Final diseare or condition resulting in death) Due to (or as a consequen		TRACT				WEERS
	Examiner		MISTASTA		PROST	ATE CI	INCER		2 YEARS
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ice of):			-17-		
	xacut	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequent	ice of):					
8760,	ate ba exacuted hysician and the burial-transit	calE	d						
9	ntificat ng phy as th		IF FEMALE:						
Вох	death cartifics e attending ph id for use as tl	lan/h	23b. Was decedent pregnant 1 Live birth 2 Fetal de	ath 3	Ectopic pregnancy			23d. Date of deli	very Day Year
0	9 9	Physiclan/Med	1 Yes 2 No 4 Pregnant at time of death	n 5∐	Other (specify)				
Ω.	res that the igned by th be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause giver	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ecords,	law requires as been sign 2 should be			<u> </u>			1 🗆 Yes	2XNo 3□Pro	bbably 4 🗆 Unknown
ecc	a law r has be je 2 sh	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
al B	Th ate pag							od? death? No 1 ☐ Yes	2 □ No
Vital		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER.	/Outpatient	t 3□ DOA Other		n (Check only one)	ce 6 Other (Spec	the)
J of			27. Manner of Death 28a. Date of Injury 28	b. Time of Injury	28c. Injury a		28d. Describe how		
Sio	Attending F r death. sctor: After by the funera	catlc	2 Accident investigation		M 1 □ Ye	es 2 □No			
Division	fter Sire on by	Certification:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medicel Exeminer: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time restigation, in my opi	, date and place, nion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License			I. Date signed (Month	
			1/2m (willing)		131	136	0	CTOBER 4	,2005
			30. Name and address of person who completed cause of death (Item 23 BLIAN C. WACLACE MW) 9 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	Ba) (Type, I	Print)	110	N D.		1 2 - 21
	Sta	to.	31. Date filed (Month, Day, Year) 32. Restrar's Signature	003	RILDR	IDE K	U. DAL	1 mari,	My 21236
	Registi		OCT 0 5 2005	B 6	book				

1 - State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 34215								
1 - State Registrar	State o	of Maryland / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death		enne () ()	5	34215
1. Decedent's Name (First, Middle, Last) Rebecca Ann Cizewski					2. Date of Death Month October		2ď05	3. Time of Death 5:44 A M
4a. Facility Name (If not institution Anne Arundel Me	4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel				
5. Social Security Number	6. Sex 1 □ M 2 X F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	9. Birthp Cour	place (State or Foreign

Funeral

Physician

/Medical

Examiner

AKG

Director

death with the Maryland item 27 is marked other than "naturel", or iteme 23a or 28e-1 ehow other traumatic event, the Madical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Medical Exemplana

Baltimore. Maryland 21215-0036

Examiner requires that the death certificate be executed attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760 been signed by the should be detached has certificete or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di this

 Birthplace (State or Foreign Country) Days 1 □ M 2 K F Yrs. 213-73-3274 4 12 06/02/2005 Annapolis, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland | Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16020 Alderwood Lane 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Btack, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Patrick Cizewski ပ Mary K. Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary K. Owens/ Mother 16020 Alderwood Lane Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 10/20/2005 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WHISC ACTY tmmediate Cause (Final disease or condition resulting in death) Physician Probable Cardiac Arrythmia /Medical Due to (or as a consequence of): Myocardial Fibrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Complications of Congenital Heart that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XXYes 2 □ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Clineck unity one) 29b. Signature and title of certifier 29b. Signature and title of certifier

State Registrar and manner stated

RU310, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA 31. Date filed (Month, Day, Year) 8 2005

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**SM## Continued on the cause of the cause

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland

29d. Date signed (Month, Day, Year)

October 15, 2005

State of Maryland / Department of Health and Mental Hygier 🔎 🛭 🖯 5 34216 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 6, 2005 Condatore **Physician** Frank 2:10A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1931 Red Oak Drive Adelphi Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1☐M 2□F Days Director 579-20-9519 80 April 1,1925 Washington, D.C. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f ehow Injury or other traumatic event, the Medical Examinar must be notified at Maryland Prince George's Adelphi 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1931 Red Oak Drive 20783 United States death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Item any injury <u>or other trainment</u> Black, White, etc. 1 XYes 2 No If Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: If Yes, Give Year or Dates: WWII ò 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician Music 1 - 417. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore Condatore Filomena Capone ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Condatore -wife 1931 Red Oak Drive Adelphi, Maryland 20783 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/6/2005 Alexandria, Virginia *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit certificate be executed Causa (Cliseasa or iriju that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated To the within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 51377 October 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Wallmark, 9707 Medical Center Drive, #300 Rockville, Maryland 20850 M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 07

2005

			For State Registrar	State of N	Maryland		ırtment of H <i>tificate of L</i>		nd Mer		iene •200	5	31.217
		п	Decedent's Name (First, Midd	tle, Last)						Date of Deat	h	U	3. Time of Death
	Physici		AOCHI CHEN							Month TOBER 5	Day 2005	Year	5:45 PM
	/Medi Examir		4a. Facility Name (If not institution	on, give street and numbe	er)		4b. City, Town, or	Location of		- -	4c. County	y of Death	
			HEBREW HOME OF GR	EATER WASHINGTO	ON		ROCKVILLE				MONTGOM	ÆRY	
	Funeral		5. Social Security Number		Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min /	Date of Birth Month, Day,	Year)	9. Birthp	lace (State or Foreign
ı.	Director		618-52-7726	1⊠M 2□F	86	Yrs.	Monuta Days	Hours	JU	LY 24,	1919	CHINA	L
	and w		Usual Residence of Decedent 10a. State 10b. Count	v	10c City	Town or Lo	ration						04 1-14 05 11 11
	show	5					Zation:						0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	he M	Director	MARYLAND MONTGO	MERY	ROCKV	ILLE	T						
	with	2					10f. Zip Code			10	Og. Citizen of		try?
	eath	eral	199 ROLLINS AVENU	E, APT. 722	at Ever in II C	12.1	20852		-0 (0*			3.A.	
	ter d Itam	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Ma	Armed Forces	s?		Vas Decedent of Hi Yes, specify Cuba	n, Mexican,	Puerto Rica	n, etc.)		ce - Americ ck, White,	
336	urs al	þ	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	_	1	☐ Yes 2🖾 No	Specify:			Specif	y: ASI	AN
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. ad othar than "natural", or Itams 23a or 28e-f show avent, the Medical Examiner must be notified at	Completed	15. Decede	nt's Education		16a. Deced	ent's Usual Occupa	tion			16b. Kind of B		
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21	e filed within al Hygiene. I othar than ' vant, the We	PO.		2		ACCOUN	TANT				CITY GOV	ERNMEN	T
2	al Hy al Hy I oth	Be (17. Father's Name (First, Middle	, Last)				18. Mother	s Name (Fir	st, Middle, N	laiden Surnan	пө)	
Na	should be id Menta markad matic av	ဂ္	CHUAN-SHEN CHEN					DING C	HEN				
Maryland	2 should be f and Mental I is markad of raumatic ava		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Street a	nd Number	or Rural Ro	ute Number,	City or Town,	State, Zip	Code)
	T		MR. MICHAEL CHEN/	SON			RADSHAW TER	RRACE,	SILVER	SPRING,	MARYLAN	ID 2090	5
ore	of H		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from Stat	0.00	nce of Dispos metery, crem	sition (Name of atory or other place	9)	Date	2	Oc. Location -	City or To	wn, State
Ē	a line in the line		`4 ☐ Donation 5 ☐ Other (1		VEN CEMETER		/11/200	5 S	ILVER SP	RING,	MARYLAND
Baltimore,	permit. Pages 1 and Department of Heall Important: If itam 2 any injury or other once.		21. Signature of Funeral Service	Licensee		. 22.	Name and Addres	s of Facility	HINES	-RINALD	I FUNERA	L HOME	, INC.
	402 60		220 Part Fater the diagram	, received			800 NEW HAN					, MARY	
н			23a. Part1. Enter the disease, o shock, or heart failure. Lis	it only one cause on each	line.								Approximate Interval Between Onset and Death
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	uted 3 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<									
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ion	Attanding r death. actor: After by the fune	atloi	Natural 5 Pendi	ing (Month, D igation	ay Year)	Injury	Work	? 'es 2 □ No					
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Ö	tal or A	Certification	T I TOTAL COMMENT	building, e	etc. (Specify)					City or Town,	State)		
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyi	ng Physician: To the bes Examiner: On the basis	of my knowi	ledge, death	occurred at the time	e, date and prince	place, and d	ue to the cau	use(s) and ma	nner as sta	ited.
	To the within 24 To tha F complete	Med	5116)	and manner s	stated.								
		-	29b. Signature and fittle of certifie		. 7		29c. License	number		1	d. Date signed		
•	3		- W/109	man.	rui)		1/18	007		0	C1060	20	5 2005
			30. Name and address of person	TEL 1	death (Item 2	23a) (Type, P	rint) Flewsel	D.	71.1/	110	110	200	5, 2005
- F	Sta	te	31. Date filed (Month, Day, Year,		trar's Signatu	18 - 1	while I	y Te	Jul V	- C		-00	3 4
	Registr	ar	OCT 0'	7 2005 France	ic B	A STATE OF THE PARTY OF THE PAR	WEL.						

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	Examin		4a. Fecility Name (If not ins					4b. City, T	Town, or L	ocation of [Death			County of Dea		
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	Funeral Director		5. Social Security Number 221–12–4033		7. Ag	97	last birthday) Yrs.	If Under Months	Days		Min.	Date of Birth (Month, Day -2-1908	, Year)	9. Bir	thplace (State of ountry) Md.	r Foreign
	and and		Usuel Residence of Deced 10a. State 10b. 0	County		10c. City	y, Town or Lo	cation				``			10d. Inside Cit	ty Limits
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	the	Director	10e. Street and Number			L		10f. Zip	Code				l0g. Citi	zen of What Co	ountry?	
	h with	al D	211 Spruce	St.				2	1875				US	A		
	deat deat	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	S. 13.			panic Origin	? (Specif	y Yes or No-		14. Race - Ame Black, Whi		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Merital Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f ehow other traumatic event, its Medical Examers must be redified at	by	1 ☐ Never Married 2[3X] Widowed 4 ☐ Dir		1 Yes 2X 1 If Yes, Give Year or Dates:	No	i	1 ☐ Yes 2		Specify:	dello Tik	an, 60.)			hite	
5-0	72 ho natur	Completed		cedent's Edu			16a. Deced	dent's Usual	Occupat	on rina most o	f working		16b. Ki	nd of Business	Industry	
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Ĕ	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Me	To	Clarence J. 19a. Informant's Name/Re				19b Mailin	ng Address				e Adam		alhoun_ r Town, State, .	Zin Code)	
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	Heal Heal tem		20a. Method of Disposition		Jaagneer	20b. P	lace of Dieno	eition /Nam	e of	1	Date			cation - City or		
ομ	ant of nt: If i		1 XBurial 2 ☐ Crem 1 4 ☐ Donation 5 ☐ Of		emoval from State		aron H		ner place)	10	-4-2	005	Dow	er, De.		
Baltimore,	permit. Peges 1 and 2 Department of Health a important: If item 27 is eny injury or other tra once.		21. Signature of Funeral S		90	me	morial 22	Park Name and Short	Address Fune				DOVE	er, be.		
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	More		shock, or heart failure Immediete Cause (Final	e. List only or	ne cause on each lin	10.			, or cymig,	30011 43 04	il dido or it	Jopinatory air	031,		Interval Betw Onset and D	veen
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α.	es that the de igned by the a be detached f		Part II. Other significant c	onditions cor	ntributing to death b	ut not resi	ulting in the ur	nderlying ca	use given	in Part I.		23e. Did to	bacco u	se contribute to	the cause of de	eath?
Records,	v requires been sign should be	d by										1 🗆 Y	es 2	2√0 3 □ P	obably 4 DU	Inknown
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<u>></u>	Physician: this certificantal director, I	To B	examiner? 1 ☐ Yes 212 No	Н	lospital:	nt 2	ER/Outpatien	t 3[] DO/	Other					Other (Spe	Assis	
	를 들 글		27. Manner of Death	Pending	28a. Date of Inju	ry y Year)	28b. Time of Injury	28	c. Injury a	it	280	l. Describe ho	ow injury	y occurred	Livir	ıg —
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Division	or Att	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injubul			eet, factory,	office		28f.	Location (Si City or Town			ural Route Numb	ber,
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	To th withir To th	Me	29b. Signature and title of	ertifier				29c.	License	number		2	9d. Date	e signed (Mont	h, Day, Year)	
	2		1 DX	/u/	Mn)		0	002	56	74		15	1310	/	
	2		30. Name and address of p	person who co	empleted cause of d	eath (Item	23а) (Туре,				- (,)	0	1 1	ny !N 21	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 10 **Physician** CODY 1355 PM CAROL ANN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, AUG • 14 , 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Yrs. Director 54 1951 MARYLAND 214-60-8540 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Madical Exeminer must be notified at 1 ☐ Yes 2X No WICOMICO WILLARDS MARYLAND Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35475 TINGLE ROAD 21874 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LAB SUPERVISOR MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM PHILLIPS **GERTRUDE** AMELIA MURRAY RALPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES B. CODY JR./HUSBAND 35475 TINGLE ROAD, WILLARDS, MARYLAND 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 10/6/05 DELMAR, DELAWARE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RECUVVENT **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has t lirector, page 2 s autopsy performed? 1 ☐ Yes 2 No al or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 -Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

the Maryland

death

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

29b. Signalure and title of certifier

100 G. CANDI 32. Registrar's Signature

10-4-2005

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIMMY Taylor

OCT 0 7 2005

Registrar

29c. License number

State of Maryland / Department of Health and Mental Hygiepe 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Day 30 0°5 **Physician** MARY ERNESTINE CHARLES 8:48 P_M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MOVIGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 87 Yrs. **Funeral** 9. Birthplace (State or Foreign 579-22-9124 1 □ M 💥 F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location WASHINGION 10d. Inside City Limits r then "naturel", or Items 23a or 28e-f show the Medical Examiner a ust be mutilled at ¥XYes 2 □ No Director 10f. Zip Code 20011 10g. Citizen of What Country? 10e Street and Number 5716 2ND SIRFET N.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 4 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiene. 27 le marked other then "I r treumetic event, Ine Mad Secondary (0-12) College (1-4or 5+) NURSE ASST. COVERNMENT 17. Father's Name (First, Middle, Last)
KERRY PHILLIPS 18. Mother's Name (First, Middle, Maiden Sumame)
ROSE THURSION s 1 and 2 should be fill if Health and Mental H Item 27 le marked oth Be 19a. Informant's Name/Relationship (Type, Print)
VEERA PHILLIPS / DAUCHIER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5716 2ND SIREET N.E. WASHINGTON, DC 20011 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō 14 Burial 2 Cremation 3 Removal from State GATE OFHEAVEN EMETERY <u>።</u> ፟ Department of Importent: If any injury or once. 10-8-2005 SILVER SPRING, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility JCHN T. RHINES COMPANY 3015 12TH STREET N.E. WASHINGTON, DC 20017 23a. Part 1. Enter the disease, or complications that caused the trath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner attending physician ario To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CVIMON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy 2 🗆 No 1 Tyes 21**X**No 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?
1 Tes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 A Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funere! L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely pleted cause of death (Item 23a) (Type, Print)
(MM), SVITC ZIFS WAY IKM. CENTUR, WASH D.C. 31. Date filed (Month, Day, Year) State Registrar

		1	For State Registrar	State of	Maryland	d / Depa	artmeni rtificate	t of H	lealth a	and M	ental Hyg	giene	005	3422	21
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Funei	ral				. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birt			place (State or F intry)	Foreign
Direct			212-24-6516 Usual Residence of Decedent	1⊠M 2□F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Feb. 17	, 192	29 Mar	yland	
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Hygin other	1	ne C	17. Father's Name (First, Middle, La.	st)					18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)		
/Idno		0	Lewis G. Crou	se					Mat	ude	Adalin	е Му	ers		
Mary d 2 sho th and 1 7 is ma treum			19a. Informant's Name/Relationship Dixie Crouse /								Route Numbe				
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N B is	٦.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	r as a consequ	ience of):								/	
ate be executed hysician and the burial-transit		Xan	that initiated events resulting in death) Last	c. Due to (or	r as a consequ	ience of):									
/ oU, e be ex /sician e burial		cal		d											
		8		<u> </u>											
death certificate e attending phys	3	20/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnar		DEctopic pre	ecnancy				230	d. Date of deliv	*	
		Physician/m	in the past 12 months? 1 Yes 2 No 9 Unknown		nt at time of de		Other (spe						Month	Day Yea	ır
ecords, F.O. law requires that the as been signed by th 2 should be detache	i		Part II. Other significant conditions	contributing to dea	th but not resu	ılting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of dea	th?
dS jurres jurres lu be	:	D D	HURCETCULI	W							1 □ Y	es 2 🛂	No 3 Pro	bably 4 □Unk	known
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VICAL MEC sicien: The law certificate has b	,	ompieted									autop. perfor	med2	prior to co death?	impletion of caus	se of
VICAL icien: 1 certifical		9	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or		1 🗌 Yes	2 NO	
OT VITA Physicien: rthis certific		0	examiner? 1 Tes 2 KNo	Hospital: 1 🗆 Inj	patient 2 🗆 E	ER/Outpatier	nt 3 🗆 DO	A Othe			ne 5 esid		Other (Speci	fy)	
ng ng ng ng ng ng ng ng ng ng ng ng ng n			27. Mann of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury	f 2	8c. Injury Work	/ at <br Yes 2 □ N	2	8d. Describe h				
I or Attending after death. Diractor: After in by the fune		Ica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place o	f Injury - At ho	me, farm, str	eet, factory						lumber or Rur	al Route Number	Γ,
al or all		Serie I	4 Homicide	building	g, etc. (Specify	")					City or Tow	n, State)			
UNUSION To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu		dical	29a. Certifier 1 Certifying (Check only one)	Physician: To the base aminer: On the base and manner	is of examinat	wiedge, deat ion and/or in	h occurred a vestigation,	at the tim in my of	ne, date and pinion, deat	d place, a th occurre	nd due to the d d at the time, o	ause(s) an late and pl	d manner as : ace, and due !	stated. o the cause(s)	
o the ithin i o the o the omple	-	Mec	29b. Signature and title of certifier	and maille			29c	. License	number		2	29d. Date s	igned (Month,	Day, Year)	
F ≯F 8			> William	K DA	1/10/	I UI	\cap	DA	203	91	- ,	not	19.2	1.00	
		T	30. Name and address of person wh					0		, 0			, .	0	
8			William H. Con					son	Drive	, Fr	ederick	, Mar	yland	21701	
	Stat	1	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signat	ture									
Reg	istra	r	OCT 2 1 2005		Lo	1 .								•	

			For 1 — State	State of Maryland	d / Department of		ental Hygie	2005	34222
			State Registrar 1. Decedent's Name (First, Middle, La:	A41	Certificate of	Death	Reg. 2. Date of Death	. No.	3. Time of Death
	Physici	an	REDNICE V	/EUAND	DURBIN		Month	Day Yeer	5 QUOM
	/Medio		4a. Facility Name (If not institution, give	e street and number)		or Location of Death	10/	4c. County of Deat	
	Examir	er	20966 NIANIT	LOOKE ROA	D BIV	ALVE		WICOM	0211
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la	Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign
	Director		119 S A 7301	□M 2 □ 5	Yrs.		1-26-	48	DC.
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Mary	tor	MD MICO	MICO B	WALVE				1 □ Yes 2 🗷 10
	or 28g	lrec	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
	23a 23a	ral	20966 NANT	MOKE BO	AD 218	314		USA	
	er dez	nne	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Deivorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify:	/ILITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show he Medicul Examinat trastite rightiful at	Completed by Funeral Director	15. Decedent's E	ducation de completed)	16a. Decedent's Usual Occu (Give kind of work done	upation	161	b. Kind of Business/	Industry
215	ithin 7	nple	(Specify only highest gra	College (1-4or 5+)	life. DO NDT use retir	ed)	,y		
	filed with Hygiene. other than		17. Father's Name (First, Middle, Last,	4	SCHOOL	18. Mother's Name	(First Middle Mai		10N
Maryland	d ta b	Be C	MAINI DI AAA	\		ETT	1 1 = 1	ITED	
Z	2 should and Men is marke eumatic	2	19a. Informant's Name/Relationship (Type, Printing	19b. Mailing Address (Stree	et and Number or Rura.	Route Number, C	ity or Town, State, 2	Zip Code)
Ž	and 2 lealth a m 27 is		RICHARD KIDE	SELL OTHER	20966 NAKO	TICKE RI	RIVAL	WE IMD	21814
J.G	es 1 a of He fitem r othe	- 3	20a. Method of Disposition 1 Ø Burial 2 Cremation 3	1 00	lace of Disposition (Name of emetery, crematory or other pl	ace)	ate 200	c. Location - City or	Town, State
Ē	Pages ment of ent: If it ury or o		'4 □Donation 5 □ Other (Specif		VALVE COMETE	ERY 10/12	105 B	WALVE	MD 21814
Baltimore	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Licer	1590	22. Name and Add	ress of Facility	+L Hom	E PO BO	X 61
	40 = 4 Q	Н	23a. Part1. Enter the disease, or com	clications that caused the death	BIVA!	LVE, M	D 218	14	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	Ann	at Com	a S a	,	Interval Between
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ience of:	si un	voi		3 ms
	Examiner		One was talk after any distance	h					
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	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ience of):				
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9	tificate ng phys as the	edlo		- d					
Вох	eath certific attending p for use as	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		cv		23d. Date of deli	,
	e deal he att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of de 9☐ Unknown				Month	Day Year
P.O.	ires that the death cer signed by the attendir d be detached for use	Phy	Part II. Other significent conditions of	contributing to death but not resu	ulting in the underlying cause of	Iven in Part I	23e. Did tobac	co use contribute to	the cause of death?
Division of Vital Records,	uires t signe Id be d	Completed by					1 🗆 Yes	200 3 Pr	
So	w require been si should l	lete					24a. Was an	24b. Were au	topsy findings available
Re	The la te has age 2	omp					autopsy performed 1 ☐ Yes 2 ☑	d? prior to death? 1 ☐ Yes	completion of cause of
ital	ien: 'rifica	Be C	25. Was case referred to medical			26. Place of Death		110	32-30
Ž	Physicien: this certificand director,	To 6	examiner?		Ervoupatient 3 DOA	ther: 4 Nursing Hon		e 6 ⊡Other (Spec	cify)
D C	ing P After t unera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of linjury 28c. Injury Wi		8d. Describe how	injury occurred	
isio	death ctor: ,	licat	2 Accident investigation 3 Suicide 6 Could not b		M 1 []Yes 2 □No	8f. Location (Stree	et and Number or Ru	ral Route Number.
Θį	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify	()		City or Town, S		
	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2			ysician: To the best of my knowniner: On the basis of examinati					
	the Hin 24 the Fi	Medical	one)	and manner stated.					
	with To To	2	29b. Signature and title of certifier	iM	29c. Licer	nse number	29d.	Date signed (Mont)	ı, Day, Tear)
	E NOR		20 Normal	completed cause of death (It -	(23a) (Type Print)			7.1/03	
	21110		30 Name an ordres of person who	completed cause of death (Item ASS 0 1 US	E CARROLL	ST SH	USBILL	m	21801
	Sta	ite	31. Date filed (Month, Day, Year)	005 32. egistrar's Signat	23a) (Type, Print) E. CARRON tuge Spart,	V //		/	
	Regist	ar	001 1 1 2	UUJ KAREUR A	a Moore				

State of Maryland / Department of Health and Mental Hygier ho ho ho ho1 - State Registrat Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** OCTOSIE DUSAN DUKES 8, 2005 5:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Frederick Somerford Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🖸 F Yrs Feb. 2, 1937 68 Maryland Director 214-34-9352 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 € No Maryland Frederick Frederick Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 21702 7932 Edgewood Farm Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Iteme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Financial Investment Branch Office Coordinator is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If Item 27 is marked eny Injury or othar traumatic evonant and Mental Lavina Powell George Green ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7932 Edgewood Farm Rd, Frederick, MD 21702 Arthur J. Duke/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/11/2005 Frederick, Maryland Frederick Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Ligensee Brodles 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complete tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in fallight. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) ZYRS Physician ALZHEIMER'S DEMENDA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death signed by the at d be detached for 5 Other (specify) o. 9□ Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 3/2 No of Vital : After this certification of funeral director. Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 (Mother (Specify) ပ္ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d 4 Homicide completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47611 OCTOBER 8, 2005 · Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANEY AVE # 204 FREDERICK. MO 31. Date filed (Mon Day. gistrar's Signature T'2 2005 State Registrar

trick Deal		1. For Unpend Item	State of Maryla 23a,pt.II,27,2	nd / Depa 28a-f _C pe	artment of F	lealth and N	lental Hyo tas	giene 2005	34224
Physicia		1. Decedent's Name (First, Middle,	Last)		in out or	- Cati	2. Date of Dea Month		3. Time of Death
/Medic		Patrick Mattl					October	14, 2005	7:04 A M
Examin	er	4a. Facility Name (If not institution, g Washington Coun				Location of Death		4c. County of De	
Funeral				. last birthday)	Hagerst	If Under 24 Hrs.	8. Date of Birth	Washing	
Director		215-17-3536	12 M 2□ F 28	Yrs.	Months Days	Hours Min.	(Month, Day June 1,	r, Year)	irthplace (State or Foreign Country) yland
9 8		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	veation				
Marylan	tor	Maryland Washing		lagersto					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ith with the M 23s or 28s-f	ai Direc	10e. Street and Number 20215 Robinwood	Court		10f. Zip Code 21742			10g. Citizen of What C	Country?
fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Exacular must be inclined at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 — Yes 2 Deno If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp n Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
72 hours	eted	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usual Occup	durina most of work	ing	16b. Kind of Busines	s/Industry
within sone.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired .ne Operat	,	E	Box Manufac	cturing
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exercitival manages.	To Be C	17. Father's Name (First, Middle, La Walter Patrick D				18. Mother's Name	e (First, Middle, M. Full		
Mary d 2 sho th and th 7 ie ma		19a. Informant's Name/Relationship Walter P. Deal -						r, City or Town, State,	
ore, Mass 1 and 2 by Health 27 item 27 is other tra		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		-	20c. Location - City o	
Baltimore, permit. Pages 1 ar Department of Hea important: if tiem any injury or othe		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Chemoval from State		natory`or other plac Memoria			rederick,	•
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0 80 8 8		23a. Parti. Enter the disease, or co	mille all	lue 16	21 Opossu	ımtown Pil	ke, Fred	lerick, Mar	yland 21702
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P.O. I	ysic	1 Yes 2 No 9 Unknown	4☐ Pregnant at time of a	death 5	Other (specify)			Month	Day Year
Vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certific r death. ctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as		Part II. Other significant conditions Cocaine Use	contributing to death but not re-	sulting in the un	nderlying cause give	n in Part I.		pacco use contribute to	o the cause of death?
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signe in by the funeral director, page 2 should be contained.	Completed by						24a. Was all autops perform	y prior to	utopsy findings available completion of cause of
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	Certification;	3 Suicide 6 ACould not 4 Homicide determine		ty)	eet, factory, office		28f. Location (St. City or Town Hagerst e	reet and Nurse 175 n, State) 20215	rkovinwood Ci
igen normal	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	Physicien: To the best of my known arminer: On the basis of examiner and manner stated.	owledge, death	occurred at the timestigation, in my op	e date and place a	and due to the ca	use(s) and manner as	s stated. e to the cause(s)
To the Ho within 24 h To the Fu completely	-	29b. Signature and title of certifier	A A		29c. License	number	29	9d. Date signed (Mont	h, Day, Year)
		· layure	Uniffull 1	M)	OCME			October 1	
	,	30, Name and address of person who				timore, M	laryland	21201	
State	۳ ا	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	ature	Snaul ,				

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Dhusia		1. Decedent's Name (First, Middle, Last)						2. Date of De. Month	ath Day	y Year	3. Time	of Death
Physic /Medi		Anna Thalice Mild					1	October		2005	3:5	5 A M
Exami	ner	4a. Facility Name (If not institution, give s				UL TO	or Location of Dea	th	40.	. County of Deatl		
Funeral		Kline Hospice House 5. Social Security Number 6. Sex	7. Age	(In yrs. last b	irthday)	Mount A	r If Under 24 Hrs		h V Vearl	Freder:		te or Foreign
Director		219-34-5646	M 2√2 F	68	Yrs.	Months Days	s Hours Min	Sept. 18	3, 19	937 Mar	yland	
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	n or Lo	cation					10d. Inside	City Limits
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with the Sa or 28s	Funeral Director	10e. Street and Number 7003 Rock Creek Dri	ive			10f. Zip Code 217				tizen of What Co		
death ms 2%	nera	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puel	Specify Yes or No	-	14. Race - Ame Black, White		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Estiminational be mailfied at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🚰 Divorced	1 Tes 2 N If Yes, Give Year or Dates:	0	1	1 ☐ Yes 2 ☑ No		to ricari, etc.		Specify Blac		
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		1 mil			195	01 Cato	ctin Mtn.	Hwy. Fr	eder			
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Physician		Immediate Cause (Final disease or condition resulting in death)	Myocardi			a					hou	
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e deat the att	O	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown			Other (specify)			4	Month	Day	Year
hat the sed by a detact	Physi	Part II. Other significant conditions con	tributing to death bu	ut not resulting	in the u	nderlying cause of	given in Part I.	23e. Did to	obacco i	use contribute to	the cause	of death?
w requires w requires should be	d by	Cancer Cachexia		_				10	res 2	□No 3□Pro	babiy 4	₩Unknown
s beer	ompleted							24a. Was		24b. Were au	topsy findin	gs available
VICAL DEC sician: The law s certificate has t lirector, page 2 s								autor perfo	rmed?	death?	2 □ No	or cause or
VICAL ician: ician: oertifica ector, p	BeC	25. Was case referred to medical examiner?						eath (Check only o				
ding Physician: h. After this certific funeral director,	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	ospital: 1 Inpatie	nt 2 ER/C	Outpatien Time of	K 3 DOA		Home 5 Resident			ify) Hos	pice
oding th. : After fune	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	W	ork? □Yes 2□No		,	,		
or Attending of Attending after death. Director: After in by the function	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, c. (Specify)	farm, str	eet, factory, offic	9	28f. Location (S City or Tox	Street ar vn, State	nd Number or Ru a)	ral Route N	lumber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical Co	29a. Certifier 1 Certifying Physic (Check only one)	ner: On the basis of	examination a								se(s)
To the within 2 To the complei	Med	29b. Signature and title of certifier	and manner sta			29c. Lice	nse number			te signed (Month	, Day, Yea	r)
- \$ - 0		1 HEERZi	X/.			D	44164		10/6	6/2005		
3		30. Name and address of person who co										
		A.Z. Hegazi, M.D.					Frederick	c, MD 217	02			
S Reais	tate trar	31. Date filed (Month Day, Year)	A Hegistra	ar's Signature	Soo	de						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3тт 902 п 9:25 р ^м **Physician** Month John Alfred Demchak 2__ Oct. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5527 Dartmouth Street Churchton Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Months 12 M 2 ☐ F Director 183-14-4288 85 Yrs Aug. 29,1920 PA Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location item 27 le marked other then "netural", or Items 23e or 28e-f show other traumatic event. The Madical Examiner must be notified at 10d. Inside City Limits MD Director Anne Arundel Churchton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5527 Dartmouth Street 20733 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Importent: If item 27 le marked other then "netural" or Iten any injury or other treumatic event, the Medical Exercires once. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 White ğ 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ground Maintenance Supervisor Airlines 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Afton Demchak Xenia Olkanych ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathy Demchak/Daughter 756 North Mesa Road, Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Oct. 4, Metro Crematory Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ceve 600 Wasculan disease **Physician** disease or condition resulting in death) reavy /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical ass IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? certificate Division of Vital 1 ☐ Yes 2\ No 1 ☐ Yes 2□ No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' ² 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hc To the Fun completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of dertifier 29c. License number 0 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COLDINICU, U.S. 900 Bestgate Rd. Annapolis, Und, 21401 gistrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Pearl Suter Dix Oct 4, 2005 0430 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminister Carroll 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🔀 F Yrs. 90 11, Director 217–03–1437 1915 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylal Department of Health and Mental Hygiene. Important: If item 27 le marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, It a Marical Examin at most be retified at once. MD Carroll Westminister 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed by If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Firm Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Henry Suter Alice E. Orem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherwood B. Dix, Jr./Son 2432 Neudecker Road, Westminister, MD Date 7 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 2005 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Services License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 plications that caused the deam. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Party. Enter the disease, or comshook, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSEPSI **Physician** IWEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 Yes 2 No ours after death. neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a To the Funeral C 29a. Certifier 1 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANKER TKINA 113 WE 31. Date filed (Month, Day, Year) strar's Signature 32. Re State 2005 Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Physician LAVINIA DEAN SEPT. 16, 4:45 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE CORSICA HILLS NURSING HOME CENTREVILLE 8. Date of Birth
(Month, Day, Year)
2,] 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Director 216-82-1875 1908 MARYLAND 97 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 21 No Funeral Director QUEEN ANNE QUEEN ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1720 RUTHSBURG ROAD 21657 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ģ WHITE 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME le marked other 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tant: If itam 27 is marked off 18. Mother's Name (First, Middle, Maiden Sumame) HARWOOD HOLLAND LESLYE SHARP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 DEAN ROAD, CENTREVILLE, MD 21617 DONALD DEAN/ SON Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 \ Burial 2 \ Cremation 3 \ Removal from State
4 \ Donation 5 \ Other (Specify) permit. Page Department of Important: If any injury or once. WOODLAWN MEMORIAL PARK 9-20-2005 EASTON, MD 21. Signature of Funeral Service Lines FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Parfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBROVAS CULAR INSUFFICIE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death Month Day Year 5 Other (specify) ed by the a Ö Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown been s ALTHERMER'S TYPE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 XX Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after the Funaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) D35048 cause of death (Item 23a) (Type, Print) ERIC R. CIGANEN, M.D., 2540 CENTREVILLE ROAD, CENTREVILLE, MD 21617 31. Date filed (Month, Day, Year) SEP 2 0 2005 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	arylan		rtmen tificate			and M		gien, Reg. N		05	342	229
	Physici	an	1. Decedent's Name (First, Middle, Last) Dina		Dal 1	Bello					2. Date of De OCT 6		305	Year	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution, give street 6303 Sheridan Street	net and number)		50110	-	Town, or verd	Location o	f Death			c. Count	y of Death	George	e's
	Funeral Director		220-82-7986	2 X F 7. Age	84	last birthday) Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bird (Month, Da Mar 5,	192	21	Cour	place (State ntry) uno,	
	ne Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo	rge's		y, Town or Lo Riverda	ale									City Limits s 2 □ No
	aa or 2	i Dire	10e. Street and Number 6303 Sheridan Street	et			10f. Zip		737				S.A	What Cour	itry?	
980	d within 72 hours after death with the Maryland jene. r than "natural", or Hems 23a or 28a-f show the Modical Examinating the maillisid at	by Funeral Director	11. Marital Status 12. 1 Never Married 2 Married 3 Xidentification Married 2 Married 3 Xidentification Married 12.	Was Decedent I Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:	Ever in U.		Vas Deced f Yes, spec			gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	~		ce - Americ ack, White, fy: W		
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur ne Modical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)		+)	life. L	lent's Usua kind of wor DO NOT us USEWI	rk done d se retired	lurina mosi	of worki	ng		Kind of B	Business/In	dustry	
and 2	be file ital Hyg od othe event,	Be	17. Father's Name (First, Middle, Last) Archangelo Bristo	ot		ПО	isewi	16			(First, Middle,	Maide				
ary	ges 1 and 2 should be it of Health and Mental I If item 27 is marked of or other treumatic eve	T ₀	19a. Informant's Name/Relationship (Type	Print)				•			I Route Numbe			, State, Zip	Code)	
e, ≥	1 and Health em 27 ther t		Anna Barr - Daught	er	20b. P	lace of Dispo	sition (Nan	ne of			erdale			0737 - City or To	own, State	
mor	Pages nent of int; if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren `4 ☐ Donation 5 ☐ Other (Specify)	noval from State	0	emetery, cren ropoli	natory or o	ther plac		0/7/	2005				Virgi	inia
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Fineral Section 200	ry							ch's Fi					31
	Physician		23a. Part1. Enter the disease, or complica shock or hear failure. List only one Immediate Cause (Final disease or condition	cause on each lir	10.	h. Do not enti	,		g, such as	cardiac c	r respiratory a	rrest,			Approxima Interval Be Onset and	itween
8760,	/Medical Examiner bhysician and the burial-transit	ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as	D-e a consequ	men of):	tia	, a	dva	nce)				Year	<u></u>
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	I death 3	Ectopic pr							ate of delive	,	Year
<u>α</u>	quires that n signed by uld be deta	ρ	Part II. Other significant conditions contri Atheroscle	_	ut not resi	ulting in the ur	nderlying c	ause give	on in Part I.		23e. Did to		use con		he cause of o	
of Vital Records,		Completed	Coronary Ar	tery Di	seas	36					24a. Was autop perfo 1 \(\text{Yes}			Were auto prior to co- death? 1 \(\text{Yes} \)	ppsy findings mpletion of a	available cause of
Vita	sicien: certific rector,	o Be (25. Was case referred to medical examiner? 1 Yes	pital:		ER/Outpatien	t 3 DC	Othe		of Death	(Check only o		6 🗆 🗆	her (Specif		
ion of	ding After fune	-	27. Manner of Death Natural Accident investigation	28a. Date of Inju (Month, Da	ry	28b. Time of Injury		8c. Injury Work	at		28d. Describe I				<u>Y)</u>	
Division	i Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injude	ury - At ho c. (Specify	ome, farm, str	eet, factory	r, office			28f. Location (3 City or Tox	Street a vn, Sta	ind Numi te)	ber or Rura	vi Route Nun	nber,
	Hos Hor Fur Iely	edicai (29a. Certifier (Check only one) 1 Certifying Physic Certifying Phy		examina											s)
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R	(10)		30. Name and address of person who com Stephanie Tri	foglio &	eath (Item	7 50 O	Print) Green	way	Cen	ta Z	rive G	rec	n be	1+ n	C 0 2 0	30
ĺ	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 7 2005	32. Registra	ar's Signa	Spore	No.									

CPM 05-07074 Christopher Fink

DHMH 17 Rev 1/2001

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	光流 。		1. Decedent's Name (First, Middle, Last)	1		Ce	rtitica	te of L)eath	2. [Date of Death	1	Year	3. Time of C	
	Physici /Medio		CHRISTOPHER OTHA	FINK			1			00	otober.	T	2005	23:35	М
*	Examir	er	4a. Facility Name (If not institution, give Holy Cross Hospita				1		Location of D pring	Death			ounty of Death		
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7	Funeral Director			(M 2□ F	1	O Yrs.	Months	Days	Hours	Min. (A)	Month, Day, pril26	, 1 99	5 Mar	yland	
9	pug 🔉		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City	Limits
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	h with the	Funeral Director	10e. Street and Number 3930 Blackburn Lar	ne, #14			10f. Z	ip Code 2086	66			_	n of What Cot ed Stat	-	
920	iges 1 and 2 should be filed within 72 hours after deeth with the Maryland 11 of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at	þ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:		i	Was Dec If Yes, sp		spanic Origin , Mexican, P Specify:	? (Specify Puerto Rica	Yes or No- n, etc.)		Race - Amer Black, White pecify: W11	, etc.	
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Dece (Give	dent's Us	ual Occupa ork done d	tion uring most of	f working		6b. Kind	of Business/I	ndustry	
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lan	ked o	To Be	Robert Eugene Finl	ζ							ne Hen		,		
Maryland 21215-0036	d 2 shoulth and N 27 Is mai		19a. Informant's Name/Relationship (Ty Gloria Anne Hensel										own, State, Z Lle, Mi	p Code) ryland	20866
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 Is any injury or other tra ance.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F		0	Place of Disponentery, cres	matory or	other place		Date / 22/20			tion - City or I		
altin	permit. Pa Depertment Important any injury		4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licens		1 vy	Hill							el, Mau De. PA	yland2(
0	2019	1	23a. Part1 Ther the disease, or compl	Courses	1	4	1400	Powde	r Mill	Road	l Belt	svil	le, Mai	yland2(705_
760,	bath certificate be executed attending physician and attending physician and to take as the burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as Due to (or as Due to (or as	a conseq	uence of):									
P.O. Box 68	0 0	Completed by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	∃Ectopic ∃ Other (:	pregnancy specify)				230	d. Date of deli Month	-	ear .
	Se 70 90	by Pt	Part II. Dther significant conditions co			•	, ,	cause give	n in Part I.		23e. Did tob	~		the cause of de	
ord	w require been signored should b	ted	Cerebral dysgenesi	s, seizur	e di	sorder				_	1 🗆 Ye	s 2 🗖	No 3 ☐ Pro	bably 4 □Ur	nknown
Vital Records,	e law has b	omple								_	24a. Was ar autopsy perform	,	prior to c	opsy findings avompletion of car	vailable use of
ita	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?							Death (Ch	neck only one)			
Division of V	ling Phys I. After this Iuneral di	ို	1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry	ER/Outpatier 28b. Time o Injury		28c. Injury Work	at	28d.	5 Reside Describe ho		Other (Spec	rfy)	
Divis	l or Atter after des Director	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At ho	ome, farm, st	reet, facto	ry, office			Location (Str City or Town		lumber or Ru	al Route Numb	er,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Medical C	29a. Certifier (Check only one) 1 Certifying Phy XIX Medical Exami	sician: To the best ner: On the basis of and manner sta	f examina	wiedge, deat tion and/or in	th occurre	d at the tim on, in my op	e, date and p inion, death	place, and o	due to the ca t the time, da	use(s) ar te and pl	nd manner as ace, and due	stated. to the cause(s)	
	To the within To the comple	Mec	29b. Signature and title of certifier	14.0			2	9c. License OCM	number		25		igned (Month		
			large	Halla	11	my		111 P			D-1-'			, 2005	201
			30. Name and address of person who co	ompleted cause of d	leath (Iten	n 23a) (Type,	, Print)	LII P	enn St	reet	Dal [1	more	, mary	land 21	ZUI
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature	· · ·								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Stanley targuharson 10 6 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Snow 4:11 Workester Harrison Assisted Living If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Days Hours Yrs. Nov. 1, Director 265 22 1379 89 1915 Bahama Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "neturel", or items 23a or 28a-f show treumetic event, the Medical Exer is at must be notified at MD Worcester Ocean City ¥Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10626 Point Lookout Rd. 21842 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Anned Forces?

√C|Yes 2 □ No

If Yes, Give 1938-39

Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Miniature Golf Course 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 sl of Health ar ittem 27 ls 10626 Point Lookout Rd. Ocean City, MD 21842 <u>Herbert J. Schoellkopf</u> 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. Cape Henlopen Crem 10/8/05 Frankford, DE * 4 ☐ Donation 5 ☐ Other (Specify) 108 William St. 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 Julas. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA ADVANCED /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine that the death certificate be executed anding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant and by the atten-3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Box 68760 Division of Vital Records, P.O. or Attending Physicien: this After death.

funeral

Director: within 24 hours after To the Funerel Dire

State Registrar

27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide

29a. Certifier (Check only one)

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

M.D.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29c. License number D0062172 29d. Date signed (Month, Day, Year) 10/8 12005

POCOMOKE CITY, MD 21851

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

SHARAD A. 31. Date filed (Month, Day, Year) 1

29b. Signature and title of certified

SATYAL . Mp Legistrar's Signature

1404 MARKET ST.

-06	721		Amend item#28 1- For Amend Item Registrar/MEND#28a-f	se Type or Prin Id, perME, G848	t in Black in	delible ink.	Ensu	and M	II Copies	Are i	Legible.		
			1- State Registrar AMEND#28a-f	286& 7er'm periME, 10/14/05	, _{EMW} , _{McCo} Ce	rtificate of	Death	und i	F	Reg. No.	005	3423	32
	Physici	an	Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	ath Day	Year	3. Time of D	
	/Medic	al	Alvin 4a. Facility Name (If not institution	Fraz	ier	4b. City, Town, o	r Location	of Death	Octobe		2005 County of Dea	1743	М
	Examin	er	Frederick Men		al		erick			40.	Frede		
	Funeral Director		5. Social Security Number 220-32-6348	6. Sex 7. Age	(In yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of Birtl	h Year)	9. Birt	thplace (State or I	Foreign
	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation						10d. Inside City	Limite
	rs after death with the Marylan ", or items 23a or 28a-f ehow raminer must be notified at	tor	, , , , , , , , , , , , , , , , , , , ,	lerick		ederick						1 XYes 2	
	or 28	Director	10e. Street and Number			10f, Zip Code				10g. Citiz	zen of What Co	ountry?	
	ath w		417 Carlton		**-		742				U.S.A		
	items items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent E Armed Forces? ed 1 ☐ Yes 2 🔀 N		Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whit		
2-003p	hours after death with the Maryland tural: or items 23s or 28s-f show al Examiner must be notified at	by	3 ☐ Widowed 4 🚰 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:				Specify:	Black	
'n	72 R R	iete	15. Decedent (Specify only highes	's Education t grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during mos	t of work	ing		nd of Business	Industry acopia	
1212	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	ntenanc					mpany	-	
פַ	~ - 0 =	BeC	17. Father's Name (First, Middle,	Last)	1141			er's Name	First, Middle,	Maiden .	Sumame)		
<u>XIa</u>	should be nd Mental marked c	ToE	Nelson Ro					Vic	ina Ho	llar	nd		
Maryland	permit. Pages 1 and 2 should Department of Health and Mer important: if item 27 is marks eny injury or other traumatic once.		19a. Informant's Name/Relations			ng Address (Street							
رة م	1 and Healti em 27		Edna Frazier- 20a. Method of Disposition	-FOLMEL WIL	Annual Control of the Control	Mill R			Door		ation - City or		
baltimore,	S in a second		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Si		20b. Place of Disposer cemetery, cres	matory or other place on Mem P					159 0-		
	mit. F sartme sortan injur		21. Signature of Funeral Service I			2. Name and Addres					ney, M neral		PΆ
ñ	9 5 E 8	C	(earso	Kilkour	11 2	46 N. W	ashi	ngto	on St 1	Rock			
	Physician /Medical Examiner		23a. Part1. Enter the sease, or shock, or hear billure. List Immediate Cause (Final disease or condition resulting in death)	a. Hypoxem			g, such as	cardiac (or respiratory are	rest,		Approximate Interval Betwe Onset and De	
	D =	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		consequence of):								
	ite be executed ysician and ne burial-transli	Ical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):								
189	artifica ing ph e as th	Med	IF FEMALE:							-			
C. Box	The law requires that the death certificate be the has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)				2	3d. Date of del Month	ivery Day Yea	ar
rds, P.	quires that n signed b	by	Part II. Other significant condition	ns contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I					the cause of dea	
Vital Records,	law require as been si 2 should b	Completed							24a. Was a		24b. Were au	topsy findings ava	ailable
		Con							perfor	med?	death? 1 ☐ Yes	3.7	
V 113	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Othe			(Check only or			-	
Division or	ding Phy n. After this funeral d	ertification; To	1 XYes 2 No 27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injury (Month, Day	Year) 1770	f 28c. Injury	4 🗆 NU	A	spirate	ow injury	occurredChe	oked on	bolu:
181	i or Attency after death Director:	ficat	2 Accident investig 3 Suicide 6 Could n	ot be 28e. Place of Injur	y · At home, farm, str	Chie	163 2 X		28f. Location (Si	treet and	Number or Ru	⊖&T Iral Route Numbe	ır.
É	ai or safter	Certi	4 Homicide	building, etc.	(Specify)				City or Town	n, State)		rederick	
	e Hospitai 24 hours a e Funeral letely filled	ca	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of	examination and/or in	h occurred at the tim vestigation, in my or	ne, date an pinion, dea	d place, th occurr	and due to the c	ause(s) a	and manner as	stated.	, ,
	To the I	Medi	29b. Signature and title of certifier	and manner stat	BG	29c. License	number		2	9d. Date	signed (Month	n, Day, Year)	
	1310		10000	I Kill a	WITH	_ D371	97				ber 3,		
,	>		30. Name and address of pers no Alan H. Rohre	no completed cause of e	ath (Item 23a) (Type, West Sever	Print) oth Street	t, Fr	eder:	ick, Mar	ry1ar	nd 2170	1-4501	
•	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 7		's Signature		,		,				

			Ticac	State of Manuage / Do				
			1 - For State Registrar	State of Maryland / De	ertificate of Death		2005 362	33
			Decedent's Name (First, Middle,		crimoate of Death	Reg. N	3. Time of Do	
	Physic		ISaac	Montgomery	Gragia	Month D	ay Year	
	/Medi Exami		4a. Facility Name (If not institution,	give street and number	4b. City, Town, or Location of Deal		8 , 2005 024 Ic. County of Death	
			DorchEster Ge	neral Hospital	Cambridge		Marchester	
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birthda		(Month, Day, Yea	9. Birthplace (State or F	Foreign
	Director		213-82-0138 Usual Residence of Decedent	87 Yrs.		Dec. 7,19	17 Maryland	1
1	Maryland -f show		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City	Limits
L		to	MD Dav	chester Huy	-1001		1 Pres 2	
Y	or 28a	lred	10e. Street and Number	2110101 /101	10f. Zip Code	10g. C	Citizen of What Country?	
0	3 €	Funeral Director	207-Heigh	ts Avenue	21643		USA	
b	ours after death v al', or Items 23s Examiner must	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - American Indian, Black, White, etc.	
36	rs aft	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 1 No Specify:		Specify:	
21215-0036	72 hours after death natural, or Items 23 Iteal Examiner mus		15. Decedent's		edent's Usual Occupation	16h	Kind of Business/Industry	
215		Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) (Gillife College (1-4or 5+)	e kind of work done during most of wo. DO NOT use retired)	rking	Killd of Business/fidustry	
21	illed withir Hygiene. other then	Con	unknown	Ne	ver worked			
nd	tal Hydral Hydraud octh	Be	17. Father's Name (First, Middle, La	ist)	i i	ne (First, Middle, Maide	n Sumame)	
Z a	2 should be n and Mental ' is marked (raumatic ev	은	John	Green	Lul	a (Ur	(Knovyn)	
Maryland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship	0,100,5	iling Address (Street and Number or Ru		or Town, State, Zip Code)	-
	os 1 and of Health itam 27 other tr		DelMaria Comm 20a. Method of Disposition	unity Services P. 0 20b. Place of Dis	BOX 631 Camb		ocation - City or Town, State	3_
ΘĽ	rit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. orfant: If item 27 is marked other than injury or other traumatic event. Item 89:		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State cemetery, cr	ematory or other place)		,)
Baltimore,	permit. Page Department of Important: If any injury or once.	ш	21. Signature of Funeral Service Lie	censee .	S Mem. Park 10/ 22. Name and Address of Facility		aston, Marylai	
m	Depa impo any ii	HII	Janelle.	M. Donnes	Henry Funeral	Home, P. A.	hald a MD DV	. 15
	- 7.		23a. Part Inter the disease, or co	omplications that caused the death. Do not early one cause on each line.	nter the mode of dying, such as ordiac	or respiratory arrest,	Approximate Interval Betwee	
	Physician	ļ II	Immediate Cause (Final disease or condition		twation		Onset and Dea	ith.
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	Lammer	_	Sequentially list conditions,	b. Sepsis				
	led nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	al-trag	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence of);				
760,	eath certificate be executed attending physician and for use as the burial-transit	cal	(d				
99	tificat ig phy as thi							
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery	
	0 0	by Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month Day Year	r
P.0	hat thi d by t letach	Phy	9 Unknown					
ds,	g g	l by		contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death	- 11
Ö	w requir been si should	etec	O TO TO TO	1020			No 3 Probably 4 Unkr	nown
Records,	has ge 2	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause	ilable e of
Vital	in: The	e Co	25. Was case referred to medical			1 Yes 2 No	death?	
>	Physician: this certifica ral director, I	To B	examiner?	Hospital: Inpatient 2 ER/Outpatie	Deber	th (Check only one)	S (70)	
	g Ph ter th		27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Residence 28d. Describe how inju		
Division	ittandir death. stor: Af the fur	atlo	1 Natural 5 Pending investigat	ion	Work? M 1 ☐ Yes 2 ☐ No			
Š	or Att fler de liracte n by t	Certification:	3 Suicide 6 Could not determine		reet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,	
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		200 2000					
:	Hos 24 ho Fun etely f	Medical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, dea aminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occur	and due to the cause(si red at the time, date and) and manner as stated. If place, and due to the cause(s)	
:	o the	Me	29b. Signature and title of certifier	and market stated.	29c. License number	29d. Da	te signed (Month, Day, Year)	
}	- > - 0		> 918 (xl	Vidmun!	U. DOOG1822	10	108/2005	
		1	30. Name and address of person wh	o completed cause of death (Item 23a) (Type		0.440=	6E, MO UG13	
			0140 02 00	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	BOU BYRN ST.	CAMPEID	6E, MO UG13	,
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Secrit 1			
	Registr	ar	90177	LUUS Meen 15 A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fh 8848 10-25-05 wt State of Maryland / Department of Health and Mental Hygie 20 0 5 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Year 1640 M **Physician** rnestine /Va OMI 2005 oveen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Ecston Talbot If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F Days 213-16-884 Usual Residence of Decedent Director Jan. 29,1924 Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County items 23s or 28s-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director aroline GW reston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 2235 1655 Creek Road Marsh 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 0 Specify: 3 Widowed 4 Divorced Black "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: if item 27 is marked other than "na sny injury or other treumatic event, the Medic one. College (1-4or 5+) Elementary/Secondary (0-12) 1-actory Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ford Johnson -eona Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Date 20c. Location City or Town, State 233 W, 140 Shirlee 20a. Method of Disposition Washington Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mt. Pleasant Cenetery
22. Name and Address of Facility Preston, Maryland 10/15/05 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee HENRY FUNERAL HOME, P. A. 23a. Part. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate anelle Immediate Cause (Final disease or condition resulting in death) Cardiac **Physician** - arrythmia /Medical Due to (or as a consequen-Examiner ortern oronam Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Physician/Medical Examine and I-transit The law requires that the death certificate be executed physician ar s the burial-to P.O. Box 68760 the attending p use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2€ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 (2) Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) SOLLING Easton, Mr MY Registrar's Signature State Registrar

rnestine

			1100001	State of Maryland					one			-
			1 - State Registrar		-	tificate of			g. No. 0 0	5 3	423	5
	Physici	200	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month			Time of Dea	
	/Medic		Margaret H. Grot						7 ^{Day} 200		20 I	РМ
	Examin	er	4a. Fecility Name (If not institution, give st. Sunshine Acres A		ina		r Location of Dea	th	4c. County of			
- 5.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs			9. Birthplace Country)	(State or Fo	reign
500	Director		2//-10-2000	M 20XF 92	Yrs.	Months Days	Hours Min	May 11	,1913	Mary]	land	
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Ir	nside City Li	imits
	Many Ind a	ţō	MD Harford	d Whi	lte H	all				1	□Yes 2X	No
	or 28s	lrec	10e. Street and Number	_		10f. Zip Code	. 1	10	g. Citizen of Wi	nat Country?		
	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or teme 23a or 28a-f ahow int, the Mauleal Evanding Figural be notified at	Funeral Director	4970 Jolly Acres			2116			U.S.A			
	ter de Item	nue	11. Marital Status 12 Never Married 2 Married 12	 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 	13. V	Vas Decedent of H Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- American In , White, etc.	idian,	
036	urs af	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	Whit	:e	
21215-0036	72 ho	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced (Give	lent's Usual Occup kind of work done OD NOT use retired	nation during most of wo	orking	6b. Kind of Bus	iness/Industry	У	
121	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		od NOT use retired cetary	d)		Colle	age		
2	Hygin other	Be Co	17. Father's Name (First, Middle, Last)		Deed	ccary	18. Mother's Na	me (First, Middle, M				
/lan	Mental Mental arked c	To B	George Hines				Ella	Millar	d			
Maryland	and and le m		19a. Informant's Name/Relationship (Type David S. Groton,					ural Route Number,				1
	1 and Heelith em 27 ther to		20a. Method of Disposition	30h Pla	ne of Disno	cition /Nama of		t. 204, Pue	20c. Location - C			
TO T	Peges nent of I ant: If ite		1 XBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Ver	netery, crem non	United t Cemete	oru Oct	20.	White I			
Baltimore,	permit. F Departmi Importer Iny injur		21. Signature of Furreral Service Licenses		22.	. Name and Addre	ss of Facility J.	J.Harte				. Ind
<u> </u>	88 = 8	1.11	Mukael W. 1	kunane	2	4 Secon	d St.,	New Fre	edom,	PA 17	349	7)
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. e cause on each line.	Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arre	st,	Inter	roximate rval Betweer et and Deat	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SUSIS Due to (or as a conseque	200 of):		^					
ü	Examiner		Mark Mark Addition of the Control of	congest	IVE	heart	Kallen	l				
1	6 =	Iner	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):	/	10 2					
of	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	emen	the			-		_
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687	tificate ig phys as the	edi		7								-
Вох	leath certifica attending ph I for use as ti	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnance 1 Live birth 2 Fetel de		Ectopic pregnancy	1		23d. Date Mont	of delivery h Day	Year	
о. П	that the death hed by the atter detached for u	Physician/M	1 ☐ Yes 2 ØNo 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	th 5 ☐	Other (specify)			Mont	II Day	T Bal	
o.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	y Ph	Part II. Other significant conditions conti	ributing to death but not resulti	ing in the un	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	oute to the car	use of death	1?
Vital Records,	w requires t been signe should be	ed by						1 🗌 Ye	s 2 T No 3	Probably	4 🗆 Unkn	own
eco	e law requ has been je 2 shouk	Completed						24a. Was an		ere autopsy fi		
<u>~</u>	: The cate h page	Соп						perform 1 ☐ Yes 2	ed? de	ath? ☐Yes 2☐I		
Vita	ding Physician: The n. After this certificate ha funeral director, page	o Be	25. Was case referred to medical examiner?	ospital:	210	Oth	00	ath (Check only one				
o	y Phys ar this eral di	H-14	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury 2	8b. Time of	28c. Injur	y at	Home 5 Resider			ssiste IVMG	-4_
ion	Attending I ir death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	k? Yes 2 □No				1	
Division	after deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Str City or Town,	eet and Number State)	or Rural Rou	ite Number,	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	al Ce	29a. Certifier 1 1 Certifying Physi	cian: To the best of my knowle	edge, death	occurred at the tir	ne, date and place	e and due to the co	usa(s) and man	ner as stated		
	To the Hospitel within 24 hours To the Funerel completely filled	edical	(Check only 2 Medical Examine one)	er: On the basis of examinatio and manner stated.	n and/or inv	estigation, in my o	pinion, death occ	urred at the time, da	te and place, an	d due to the o	cause(s)	
	To the To the comp	M	29b. Signature and title of certifier	- 44.0		29c. Licens		29	d. Date signed	/	Year)	
,	à		· Cleur	o Mr)			7955十		10/18/	.05		
^	4		30. Name and address of person who com E 1174074 Sch Leyn or		3a) (Type, I	K Rd	Monks	ton Mel	21111			
-5	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signally		will						
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™allace Gaymon, Jr. 05-06 crn

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100	· = =	Decedent's Name (First, Middle, Last					2. Date of Deat	h		3. Time of	
Physic /Medi		Wallace Gaym					Septemb	er 26,	2005	1:39	Рм
Exami	ner	4a. Facility Name (If not institution, give	·	0.01	4b. City, Town, or L			4c. County		1 _	
		5900 St. Moritz Ro		nt 201 yrs. last birthday,	Temple I	1111S If Under 24 Hrs.	8. Date of Birth	Prince	,		- Faraina
Funeral Director			YM 2DE	29 Yrs.		Hours Min.	July 22	Year)	9. Birthplac Country Wash	h., D	C
yland how		10a. State 10b. County		City, Town or L					10d	d. Inside Ci	ity Limits
death with the Maryland ms 23s or 28s-1 show Litals Le Italified at	Director		George's		Сар	itol He	ights			1 XYes	2 🗆 No
with the	2	10e. Street and Number	// 100		10f. Zip Code	207/2	1	0g. Citizen of W			
eath	Funeral	4163 Southern	Ave., #102	nIIS 13	Was Decedent of Hist	20743	activ Vac or No.		ed Sta		
b ₽ 🖺	by Fun	1 Narried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	10.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ▼No	Mexican, Puerto	Rican, etc.)		k, White, etc	C.	
2 1 2 1 5-0036 d within 72 hours afl giene "paturel", or nr the "naturel", or	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Dccupation	on		16b. Kind of Bu	ısıness/Indu	stry	
within 72 ane.	Completed	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done dui DO NOT use retired)	ring most of work.	ing				
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Viana vuld be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last)	C		1	8. Mother's Name	e (First, Middle, A				
C 5 5 5 5	၉	Wallace Ga	*	19h Maili	ng Address (Street and	d Number or Pur		cia Per		'a da l	
Ma nd 2 sl lith an 27 ior		Shanelle Lewis			63 Souther						20743
s 1 and if Healing Item 2		20a. Method of Disposition	1	b. Place of Disp		1		20c. Location -			
Peges Peges ment of ant: If it lury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			Crematory	l	2005	C1	inton,	, MD	
battimor permit. Peges Department of Important: If it any injury or o		21. Signatore of Funeral Service Licens	ee Toward		2. Name and Address	of Facility St	ewart Full., N.E.	uneral 1	Home		
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/Medical		resulting in death)	Due to (or as a con:	sequence of):	14 MEXICO 1	wood	ua-				
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oy the dached	Physi	1 Yes 2 No 9 Unknown	9□ Unknown								
VIIAI RECORDS, P.O. BC sicien: The law requires that the death certificate has been signed by the atter rector, page 2 should be detached for u	by P	Part II. Dther significant conditions con	ntributing to death but not	resulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contri	ibute to the	cause of de	eath?
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RECOLUS, he law requires t has been signe ge 2 should be o	Completed						24a. Was ar		Vere autopsy rior to compl	y findings a	available
The law The has b	Son						perform	ned? de	eath?	□ No	luse or
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Phys rathis	P	1 Tyes 2 No	1 ☐ Inpatient 2 28a. Date of Injury	2 ER/Outpatier 28b. Time o		4 Nursing Ho	me 5 Resider	nce 6x Othe	r (Specify)	at sc	ene
OVISION Tor Attending after death. Director: After in by the fune	E E	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Month, Day Year	Tourn	Work?	s 2000		ect si			
After After dea	Hica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A	t home, farm, st		-	28f Location (Str	eat and Numbe	ar or Pum I P	oute Numi	ber I
tel or safte	Certification:	T Comercia	building, etc. (Spe	DVL 2			#201	State) 590	OSTINS	Witz	14
To the Hospitel or Attending Physicien: whin 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ledical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my liner: On the basis of examinant and manner stated.	knowledge, deat nination and/or in	h occurred at the time, vestigation, in my opin	date and place, a ion, death occurr	and due to the ca ed at the time, da	use(s) and mar te and place, a	ner as state	e cause(s)	
To the To the Comp	X	29b. Signature and title of certifier	e + () -	1	29c. License n		29	d. Date signed	(Month, Day	y, Year)	
		> Carolt	allan u	ud		O.C.M.E.	S	eptembe	r 27,	2005	
R(1)		30. Name and address of person who co	impleted cause of death (I	/		- Roled	more M-	evil and	21 201		
Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	gnature	Penn Street	, Dalti	поге, ма	Lyrand	<u> </u>		
Regist		OCT 0 7 2005	leve &	buch	1						
DHMH 17 Rev 1/2	001			1							

LORRAINE HOLMES

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	•	1 - State Registrar amended #26 1. Decedent's Name (First, Middle, Last)	5/10/11/05	/wchd/ Ce	ertificate of	Death ma	p 2. Date of De	Reg. No. 2	- 21.22
/sicia			Holmes				Month OCT •	Day 1, 2005	4:30 A M
amine		4a. Facility Name (If not institution, give si				or Location of Dea	ith	4c. County of Dea	
eral		SALISBURY REHAB & 5. Social Security Number 6. Sex		ENTER (In yrs. last birthda)	y) If Under 1 Year		s. 8. Date of Bir	th 9. Bi	rthplace (State or Foreign
tor		213 30 0000	M 2XIF 5	6 Yrs.	Months Days	Hours Min	(Month, Da 2/25/	y, Year)	country)
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	Location				10d. Inside City Limits
	Director	Maryland Wicomico		Salisbur					1X Yes 2 ☐ No
		10e. Street and Number 200 Civic Ave.			10f. Zip Code 218	04		10g. Citizen of What C	Country?
	Funeral	11. Marital Status	2. Was Decedent Ev Armed Forces?	er in U.S. 13	. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Specify Yes or No		
	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		,,	Specify: Af1	rican erican
		15. Decedent's Educ (Specify only highest grade	eation	16a. Dec	edent's Usual Occure kind of work done	pation	orking	16b. Kind of Business	
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	. DO NOT use retire nemaker	ed)	,,,,,,,g	Domestic	
	Be Co	17. Father's Name (First, Middle, Last)		11011	Chance	18. Mother's Na	me (First, Middle,	, Maiden Sumame)	
	To	William C. White				_	Minton		
		19a. Informant's Name/Relationship (<i>Typ</i> Ernest White/son	oe, Print)	19b. Mai 332	iling Address <i>(Str</i> ee 200 Dagsbo	oro Rd.,	Parsonst	er, City or Town, State,	Zip Code) 849
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	20b. Place of Disp cemetery, cre	position (Name of ematory or other pla	ace)	Date	20c. Location - City or	r Town, State
		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	1		y Cremato		/5/05	Salisbury	
		Yould R I L	gener (500	Holloway 501 Snow	funeral Hill Rd.	Home Pro	fessional Aury, MD 218	Association
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused th						
٦.			e cause on each line.	e death. Do not er	nter the mode of dy				Approximate Interval Between
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			1 - For State Registrar	State of Maryland		artment of H			giene 10 0	05	34238
74		吸证	Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	ith		3. Time of Death
	Physicia /Medic		Clinton L.	Herbert, Jr.				October	Day 20 2 1	Year 005	1:40 P M
	Examin		4a. Facility Name (If not institution, ga			4b. City, Town, or	Location of E	Death	4c. Cour	nty of Death	
			5734 Woodvill			Mt. A		14		rederi	
	Funeral			Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Da)	, Year)		place (State or Foreign intry)
	Director		578-46-7790 Usual Residence of Decedent	68				July 7,	1937	Wash	nington, D.C
	yland		10a. State 10b. County	10c. City, T	own or Lo	cation					10d. fnside City Limits
	a-fel	ctor	Maryland Frederi	ck M	t. Ai	ry					1 ☐ Yes 21 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	intry?
	ath w	ra I	5734 Woodville			2177				ted S	
	items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin n, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. H	lace - Ameri llack, White,	
36	I', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spec	cify: Wh	nite
2-0036	within 72 hours after death with the Maryland she. than "neturel", or items 23a or 28a-f ehow in Madisal Examinar must be notified at	ted	15. Decedent's I	Education 1	6a. Dece	dent's Usuaf Occupa	ation		16b. Kind of	Business/ir	ndustry
215	hin 7.	pie	(Specify only highest g	College (1-4or 5+)	life.	kind of work done of DO NOT use retired,	furing most of)	t working			
2121	er th	Completed	11		P1a	ite Makei					Company
Maryland	d oth	Be	17. Father's Name (First, Middle, Las					Name (First, Middle,		ame)	
Zia	ould Men Marke	2	Clinton L. Her					essie M. G			0.11
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23s or 28s-f show apprintury or other traumatic event, the Madical Examinat must be notified at an ance.		19a. Informant's Name/Relationship					or Rural Route Numbe			
,	1 and Healt tem 2		20a. Method of Disposition	tins Herbert, wif	e of Dispo	sition (Name of		Date Date	20c. Locatio	_	
0 D	ages ant of tt: If it		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemovai from State		natory`or other place et Cemetei	1	0/12/05	Erado	red als	Maruland
Baltimore,	ortan Injur		21. Signature of Funeral Service Lin	7,500				Stauffer F			Maryland
ä	Depa Impo eny li		Maxous C	amillo le				Pike Fre			21702
			23a. Part1. Enter the disease, or co- shock, or heart faifure. List on	mplications that caused the death.	Do not en	er the mode of dying	g, such as ca	rdiac or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PULHONA	R4	FIBROS	as				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequen	ce o):		1.5				1 121-
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	be sit	Examiner	Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):						
	and and Il-tran	хап	that initiated events resulting in death) Last	c	ce of):				_	-	
8760,	Attending Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be delached for use as the burial-transit	icai E									
687	tificate ig phy: as the			U							
Вох	eath certifi attending for use as	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		7c-+i			23d. I	Date of deliv	rery
œ.	deatl	icia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 ☐ Fetaf de		Ectopic pregnancy Other (specify)				Month	Day Year
о. О.	at the de by the a	Physician/Med	9 🗆 Unknown	9□ Unknown							
	res tha signed i be det	ρ	Part II. Other significant conditions	10.	ng in the u	nderlying cause give	en in Part I.				the cause of death?
ord	w requir been sl should	Completed		MELLITUS					′es 2□No	3 L Proi	babfy 4 □Unknown
ec	e law has b	nple	- K11651605	sio N				24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
<u> </u>	: The	Ö	0 6ES(TY					perfor 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 No
<u> </u>	ician certifi rector	8	25. Was case referred to medidal examiner?	Hospital:		Othe	25	Death (Check only or			
Division of Vital Records,	ding Physician: The Ih. After this certificate he funeral director, page	-T	1 Yes 25 No 27. Manner of Death	1 Inpatient 2 EH	Outpatier b. Time o	IL SELDON	4 🗆 140151	ng Home 5 Resid			(4)
on	ding th: : Afte	tion	1 Natural 5 Pending 2 Accident investigate		Injury	f 28c. Injury Work	c? Yes 2 □ No				
/isi	l or Atten after deatl Director:	ifica	3 Suicide 6 Could not determine	286. Place of Injury - At nome	, farm, st	eet, factory, office				mber or Rur	al Route Number.
Ö	s after sl Direct	Certification:	4 HOMICIOS	building, etc. (Specify)				City or Tow	,		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying F	Physician: To the best of my knowle aminer: On the basis of examination	dge, deat	h occurred at the tim	ne, date and p	olace, and due to the	ause(s) and	manner as s	stated.
	To the h within 24 To the F complete	Medical	one)	and manner stated.		20- 1	- number		and Date :		Day March
\ \	To viti	~	29b. Signature and title of certifier	H (brom me)		000	4171	7	29d. Date sign	11 / De	Doy, Year)
,	10		- Marial a	77. 900.0 /110		9:-1	1,11	0.0	, , ,	FACE	2:11
	10		30. Name and address of person wh	Physician: To the best of my knowle aminer: On the basis of examination and manner stated. A Physician: To the best of my knowle aminer: On the basis of examination and manner stated. A Physician: To the best of my knowle aminer stated. A Physician: To the best of my knowle aminer stated.	В (Туре,	THOMAS	JUHN	SON UK - 7	+203	H-EDE	10K M4
	Sta Registi		31. Date filed (Month, Day, Year) 2	2005 Signature	K A	parte					

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201 THEODORE 31. Date filed (Month, Day, Year) OCT 0 7 2005

history Me

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

OCME

29d. Date signed (Month, Day, Year)

October, 4, 2005

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1_ Katherine Louise Howell October 2005 2:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Countryside Home Fulton Howard 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Vrs 579-46-3588 68 Washington, DC Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28e-f ehow other traumatic event. Its Medical Examinar must be notified at 1 ☐ Yes 2XXIo Maryland Anne Arundel Edgewater Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3683 First Avenue 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.

other then "naturei", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: þ Specify: 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filt iment of Health and Mental H tant: If item 27 is marked off Be Alfred Richardson Thornett Lillian Louise Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward L. Howell/ Son 3683 First Avenue, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If ite
eny injury or ot XXBurial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 10-4-05 Brentwood, MD 21. Signature of Fanglal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** arcin om resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner signed by the ettending physiclen and d be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ seas-e 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ophi autopsy performe 1 ☐ Yes Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 250 No d Dother (Specify) ASS istect 1 Tyes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeret Di completely filled in 24 hours Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D 36246 05 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Roesler Rd Glen Burnie MD MO Clouine 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			1 - For State Registrar		State	of Maryla		artment of F rtificate of		nd Mental Hy	giene	005	31	4241	
	Physici	an	1. Decedent's Name (Firs	st, Middle, La	st)					2. Date of D		Yee	3.	Time of Death	
	/Media	al	Walter	J.	Har					Octobe	r 4,	2005	1:	20 A. M	
1	Examir	er	4a. Facility Name (If not in			imber)		4b. City, Town, o		Death		4c. County of Death			
33	Funeral		Northampt 5. Social Security Number	r 6. S			. last birthday)	Freder If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi	rth	Frede		State or Foreign	
	Director		215-20-9355 Usual Residence of Dece		<u> </u>	80	Yrs.	- Bayo	1,0013	Sept.	8. Date of Birth (Month, Day, Year) Sept. 1,1925 8. Birthplace (State or Foreig Country) Maryland				
	yland tow		10a. State 10b.	County		10c. C	ity, Town or Lo	cation					10d. ln	side City Limits	
	e Mar	ctor	Maryland Fr	rederi	ck	נ	hurmon	t					11	∐Yes 2Ã No	
	vith th	Director	10e. Street and Number					10f. Zip Code				en of What	Country?		
	eath v	Funeral	10648 Powell	L Koad	12 Was Dec	edent Ever in	118 123	217		2 (Const. Vac as N		SA 4. Race - An	norinan Ind	dian	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23s or 28e-f show any Injury or other treumatic event, it a Medical Evs. in or must be notified at once.	by Fun	1 ☐ Never Married 2 3 ☐ XWidowed 4 ☐ D		Armed For It Yes, Giver or It	orces? 2 No ve		f Yes, specify Cub.	an, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	Ì	Black, Wh		nan,	
21215-0036	72 ho natur	Completed		Decedent's Ed	ducation de completed		16a. Deced	dent's Usual Occup	pation	f working	16b. Kin	d of Busines	s/industry		
121	within ine. ihen *	mpl	Elementary/Secondary			1-4or 5+)		kind of work done OO NOT use retire							
	filed v Hygie other t	e Co	Unknown 17. Father's Name (First,	Middle, Last))		Auto	omobile M		C Name (First, Middle		o Deal	ersh	ip	
Maryland	iould be Mental narked o	To B	Paul			Har	per		Viol	а	Ram	sburg			
	and 2 shealth and n 27 ls n er treun		19a. Informant's Name/R Bonnie Hawe			ughter	19b. Mailir 14354	A Brown	Road	or Rural Route Numb Sabillasv	ille,	Town, State, MD 21	Zip Code .780)	
Baltimore,	Pages 1 ent of He nt: If iten ry or oth		20a. Method of Disposition 1 Burial 2 □ Crea 4 □ Donation 5 □ C	mation 3		State	cemetery, cren	sition (Name of natory or other place of Mem. Ga		Date /6/2005		ation - City o		tate	
Balti	permit. I Departm Importei any Inju		21. Signature of Funeral				22	. Name and Addre	ss of Facility	Stauffer et, Thurm	Fune	ral Ho	me,	PA	
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,8260,	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	l	c	(or as a conse	quence of);								
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.O. Box	that the death certificated by the attending posteriors as	Physician/M	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live I	tcome of pregr pirth 2 Fet nant at time of own	aldeath 3□	Ectopic pregnancy Other (specify)			23	3d. Date of de Month	elivery Day	Year	
Records, P.	9 P 9	by	Part II. Other significant of		ontributing to d		sulting in the ur	derlying cause giv	en in Part I.	23e. Did t	_	e contribute		se of death?	
eco	law requir as been si 2 should	Completed	Reine INS	SUFFICE	iency					24a. Was		24b. Were a	utopsy fin	dings available	
<u> </u>	The	Com	Weight 1	051	•					— auto perfo 1 ☐ Yes	nmed?	death?			
Vita	Physicien: this certificatal director, j	Be	25. Was case referred to examiner?	medical	Hospital:			0**		Death Check onl					
Division of Vital	ding Phys h. After this funeral dir	tlon: To		Pending investigation	28a. Date (Mon		28b. Time of Injury	28c. Injun Worl	at Nursir	ng Home 5 ☐ Resi 28d. Describe			ecify)		
Divisi	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place	of Injury - At hing, etc. (Speci	nome, farm, stre fy)	eet, factory, office	700 1 110	28f. Location (City or To	Street and wn, State)	Number or F	lural Route	o Number,	
"	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 💆 C (Check only 2 🗍 M	Certifying Ph ledical Exan	niner: On the b	best of my kn asis of examin- ner stated.	owledge, death ation and/or inv	occurred at the tin	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the ca	luse(s)	
	To the H within 24 To the Si complete	Me	29b. Signature and little of	certifier .	D			29c. License	e number		29d. Date	signed (Mon	th, Day, Y	ear)	
•) (uyel	u !	5 (a	sagn	mel	D4	10307	- MD	0	T.	1 2	005	
5	TIVA		30. Name and address of Dr. Eugene						Frede	erick. MD	21702	2			
	Sta Registr	•	31. Date filed (Month, Day	y, Year)			ature for		-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October ANNA LOIS HARNE 10:30 DM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 69 Director 214-34-0473 April 5, 1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Maryland Frederick Myersville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or itams 23a or 12737 Stottlemyer Road 21773 USA death ! Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or Itan any njury or other traumatic event, it a Medical Examinations. Black, White, etc. I □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: White 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 Registered Nurse 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hartle Bessie Sager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debora D. Fox / daughter 14009 Stottlemyer Road, Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garfield U. Methodist 10-20-05 4 Donation 5 Other (Specify) Garfield, Maryland 21. Signature of Fune al Service Licens e 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Securitially list sunctions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 3 Probably 4 Unknown bleen si 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 2X No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes ours after death.
neral Director: After this certifica
filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: No Other: 1 atient 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Con ned cause of death (Item 23a) (Type, Print) O 31. Date filed (Month, Day, DCT 2 Registrar's Signature Year) State 1 2005 Registrar

			For State Registrar	State of Maryland /		rtment of H tificate of L			iene 2005	34243
	Physici /Medio		1. Decedent's Name (First, Middle, Last, DOROTHY Ma	ie John	5			2. Date of Dear Month OCT,	Day Year 7 2005	3. Time of Death - 6:27 P. M
	Examin	er	4a. Facility Name (If not institution, give 704 EAST 167 5. Social Security Number 6. Se	57.	oirthday)	If Under 1 Year	Location of Death RICK If Under 24 Hrs.	8. Date of Birth	4c. County of Dea	th state or Foreign
	Funeral Director		219-22-5709 1D	M 28F 77	Yrs.	Months Days	Hours Min.	Month, Day,	Year) C	HORT NOWS VA
	72 hours after death with the Maryland netural', or Hems 23e or 28a-f show diest Examinar must be notified at	rector	10a. State 10b. County THED EA	RICK FRE		. /		1	0g. Citizen of What C	10d. Inside City Limits 1 ☑ Yes 2 ☐ No puntry?
	eath with	Funeral Director	704 EAST 16H	57. 12. Was Decedent Ever in U.S.	13. \	2170	spanic Origin? (Spi	acify Yas or No-	U. S	erican Indian.
5-0036	ours after d ral', or Item Examinar	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
21215-0	within ene. than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	ent's Usual Occupa kind of work done of OO NOT use retired	furing most of work	ing Q	16b. Kind of Business	un Clothing
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_	1 and 2 sho Health and I sm 27 Is ms ther traums		19a. Informant's Name/Relationship (T) ALEXANCHER LEE 20a. Method of Disposition	GADDIN 0	1150	Campbell	LST. F	HARRIS.	City or Town, State, CCRG VA 20c. Location - City or	22801
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service I cens	John	15 /2	sition (Name of natory or other place Nicky City Name and Addres	n. Oct.	13,2005 + Ry L. Ro	PRINCE GEOR	COUNTY VA
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	Physician /Medical Examiner)r	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence		e Pan	creuti	c Ca	cucer	Onset and Death
8760,	ate be executed thysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence						
O. Box 6	death certific e attending p id for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
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f Vita	ding Physician: Th h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Dutpatien	t 3 DOA Othe	26. Place of Deatl			ocify)
Division of	fter	Certification; 7	27. Manner of Death 1 Matural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury Work	at		ow injury occurred	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	le Hospi 124 hou le Funer letely fill	edical	29a. Certifier 1	sicien: To the best of my knowled ner: On the basis of examination a and manner stated.	and/or in	restigation, in my or	pinion, death occurr	ed at the time, da	ate and place, and due	e to the cause(s)
	To th To th	Me	29b. Signature and title of certifier	, a	40	29c. License	1 / 2 E	6 6	9d. Date signed (Moni	th. Day, Year) 1, 2005
	10		30. Name and address of person who co Kernan Hudhud, M		i) (Туре,	Johnson	mive,	Fred	enick (mo	21702
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 2 2000	32. Registrar's Signature	pre	U				

			1 - State Registrar	-	aryland / Depa		ealth and M	•	2005	34244
	Physici	an	Decedent's Name (First, Middle, Lass Sharon Marie Jon	•		Timodio of E	Journ	2. Date of Death Month	Day , Year	
	/Medic		4a. Facility Name (If not institution, give)	4b. City. Town, or	Location of Death	October	4c. County of Dea	
	Exami	iei	THE MEMOR	. 1		EAST	,		TALD	
	Funeral		5. Social Security Number 6. S	9x 7. Ag	e (în yrs. last birthday)	 	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign ountry)
	Director		210-40-0330	□ M 2 💢 F	58 Yrs.	World S Days	Tiodis Willing	July 30,	1947 De	Laware
,	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
5	ire, Maryland 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural; or items 23s or 28s-1 show other traumatic event, the Medical Exprinent market millied at	ctor	Maryland Dorchest	er	Hurlock					1. Yes 2 □ No
-	1 to 1 to 1	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
20	3 ath &	rai	103 Winfield Driv			21643			USA	
Ò	P e m	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces′ 1 ☐ Yes 2 🔀	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
AA	036 ours aff		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
SHARON	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural, or Items 23a, any Injury or other traumatic event, the Medical Exerts at mutals once.	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired,	ition uring most of worki	ng 16b	. Kind of Business	s/Industry
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Ť	Mar 12 shd h and 7 is m		19a. Informant's Name/Relationship (Chrystal Kramer/D			ing Address <i>(Street a</i>				
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	Bal permi Depa Impor		Jeonsuel ,	X X		06 Main St	reet, Ea	st New Ma	rket, MD	21631
		(23a Part . Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death. Do not enine.	ter the mode of dying	, such as cardiac o	r respiratory arrest,		Approximate Interval Between
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	Jing F Jing F After funer	ion	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time o lnjury	Work	at ? ′es 2.⊡No	28d. Describe how in	njury occurred	
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	Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of my knowledge, deat of examination and/or in lated.	th occurred at the time to the time operation, in my operation, in my operation, in my operation.	e, date and place, a inion, death occurre	and due to the cause ad at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
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			my SII	Strick	1	D	1723	2	10/0-	7/2005
			30. Name and address of person who					_		, , , , , ,
			Mary S. DeShields 31. Date filed (Month, Day, Year)		09 Idlewild "s Signature	d Avenue,	Easton, 1	MD 21601		
	Sta Regist	ate rar			Signature	South				

		1 - For State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	lental Hygie	(1111) 34740
Physic /Med	ical	Decedent's Name (First, Middle, Last) MARY R 4a. Facility Name (If not institution, give st.)	TACKSON	4b. City, Town, or Location of Death	OCTOBER	Day Year 3. Time of Death 4 2355 10 5 4 M 4c. County of Death
Exami Funera Director		BALTIMORE VA ME 5. Social Security Number 218-16-7321	DICAL CENTER 7. Age (In yrs. last birthday) 8 8 Yrs.	BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
be filed within 72 hours after death with the Maryland hall Hygiene. Id other than "natural", or lams 23a or 28a-f show event, the Maryland Exemple event, the Maryland exemple at the maryland event.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 7 2 /43 If Yes, Give Year or Dates: 2 2 7 46 16a. Decedent Ever in U.S. 1 16a.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I Yes 2 No Specify: Ident's Usual Occupation kind of work done during most of working DO NOT use retired)	ocify Yes or No-Rican, etc.)	10d. Inside City Limits 1 Ves 2 □ No Citizen of What Country? L.S.A 14. Race · American Indian, Black, White, etc. Specify: Block Kind of Business/Industry
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.	To Be	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type Sylva Sw. 20a. Method of Disposition 1 Burial 2 Cremation 3 Revision 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	noval from State 20b. Place of Disposemetery, created by the company of the comp	ng Address (Street and Number or Rura Landridge Beltw. Institute (Name of natory or other place) Cemeters 10/8 2. Name and Address of Facility Levery France Roll H	Route Number, City Say Canha Pate 200. 3105 Come, P. A.	COMPCV y or Town, State, Zip Code)
8 7 60, sate be executed Wedgical Mysician and the burial-transit	dical Examiner	23a. Pad. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, sui c h as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death TWO DAYS
P.O. BOX 60 hat the death certific d by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contr	4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown ibuting to death but not resulting in the u			23d. Date of delivery Month Day Year o use contribute to the cause of death? 2 ☑ No 3 □ Probably 4 □Unknown
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UNISION OF VITA To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Director: After this certifica completely filled in by the funeral director.	Certification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	the state of the s		
DIVIS Hospital or Att 24 hours after de a Funaral Direct	edical Certific	4 Homicide determined 29a. Certifier (Check only 2 Medical Examine	28e. Place of Injury - At home, farm, str building, etc. (Specify) sien: To the best of my knowledge, death r: On the basis of examination and/or in	n occurred at the time, date and place, a	City or Town, Sta	(s) and manner as stated.
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Si Regis	ate trar		32. Registry's Signature			

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State

Registrar

OCT 2 4

2005

32. Registrar's Signature

			For State Registrar	State of Mar	ryland /		rtment of H		d Mental Hy	20	0.5	31,21,7
1			Decedent's Name (First, Middle, Last,				mouto or E	Journ	2. Date of De			3. Time of Death
	Physici		Mae Pretty	man Johnso	n				Octobe	er 5.	Year 2005	11:57 P ^M
	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of De			nty of Death	
			Berlin Nursing &	Rehabilita	tion (Ctr.	Berlin			Wor	cester	•
	Funeral Director		210-14-1002	TM OVETE	(In yrs. last i 82	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. 8. Date of Bir (Month, Da Aug. 4	y, Year)	9. Birth Cou	place (State or Foreign intry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
	Aaryla F sho	ច	MD Worcest		Ber		4.011					XIX Yes 2 □ No
	28a-	Director	10e. Street and Number		Del	1 111	10f. Zip Code			10g. Citizen	of What Cou	intry?
	with 3a or	0	10218 01d Ocean C	itv Blvd	Ant.	804	21811			USA	or while ood	
	death ms 2	Funeral		12. Was Decedent Ev				spanic Origin?	(Specify Yes or No erto Rican, etc.)		Race - Amer	
ي	or tte		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	1		Yes, specify Cubar □ Yes 2 🕱 No	n, Mexican, Pu Specify:	erto Rican, etc.)		Black, White	
5	72 hours after death with the Maryland natural; or terms 23e or 28e-f show dical Examiner must be rediffed at	d by	3 XWidowed 4 □Divorced	Year or Dates:			LITES ZLAINO	эрөспу:		Spe	city: Whi	re
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	and 2 ealth a n 27 is	11	Patrick L. Johnson	(son)	2	29100	Farms La	ane, Tr	appe, Md.	21673	3	
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Johnson	permit. Page Department: Important: it any injury o		21. Signature of Funeral Service Licens	Y. Ray	lect	22.	Name and Address	s of Facility T iam St.	he Burbaq , Berlin	ge Fune , Md. 2	eral H 21811	ome
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the cause on each line	nolded th. D	not ente	the mode of dying	, such as card	iac or respiratory a	rrest,		Approximate Interval Between
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7	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	e of	1.1	11-1	Diseas Utras			V
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_	execu in and ial-tra	Examin	resulting in death) Last	Due to (or as a	consequenc	e of):						<u> </u>
8760	cate be executed physician and the burial-transit	dical		d								
· ·	rtifica ng ph as th	Med	IF FEMALE:									
Box	eath certific attending p	lan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	☐ Fetal dea		Ectopic pregnancy				Date of deliv	•
	at the dea by the al	Physici	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death	5 🗆	Other (specify)				WOTH	Day Year
٥	that the	Ph	Part II. Other significant conditions cor	ntributing to death but	not resulting	a in the und	ferlying cause give	n in Part I.	23e, Did t	obacco use o	ontribute lo t	he cause of death?
of Vital Records	The law requires that the death certification is the law requires that the death certification is been signed by the attending page 2 should be detached for use as	d by	Cardine	Arry Th	mia		, 9 9			Yes 2□No		1
j	w require been si	ete	Har line	le de					24a. Was	an 24	h Wara aut	opsy findings available
a d	The lav ate has page 2	Completed	- MSDE-MISICA	auto					- autor	osy ormed?	prior to co death?	mpletion of cause of
4	icien: Th certificate rector, pag	O O	25. Was case referred to medical					26 Place of F	1 ☐ Yes eath (Check only o	2 No	1 🗆 Yes	2 L No
5	Physicien: r this certifica	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital:	2 🗆 ER/0	Outpatient	3□ DOA Othe	c 1	Home 5 Resi		Other (Specia	(v)
ć	ding Phy h. Atter this tuneral c		27. Manner of Death	28a. Date of Injury (Month, Day)	28b	. Time of Injury	28c. Injury Work	at	28d. Describe			
	Attendir death. ctor: Al	catic	Accident investigation				M 1□Y					
Division	or Att fter d yirect in by	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, stre	et, factory, office		28f. Location (City or To	Street and Nu vn, State)	mber or Rur	al Route Number,
	pital ours a eral D	O	200 Conifice 19 Continuing Phys	niging. To the best of	mu to audad	loo dooth						
	To the Hospital or Attending within 24 hours after death 25 to 10	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination :	and/or inve	stigation, in my op	e, uate and pla inion, death oc	curred at the time,	cause(s) and date and plac	manner as s e, and due t	o the cause(s)
	To the within Fo the	Me	29b. Signature and title of certifier		1	7	29c. License	number		29d. Date sig	fied (Month,	Day, Year)
	. ,, ,		1/1/ Tire	elec	-0	رلي	Das	3769		101	610	
C.	H. 10		30 Name and address of person who co	mpleted cause of dea	ath (Item 23a	120	rint) Gasta	el Hich	va Fli	wat 10	7= le	el
	Sta	ite	31. Date filed (Month, Day, Year)	32. egistrar	s Signature	1	andle 3	1				
	Registr	rar	001112	TOUR DE LA CONTRACTION DEL LA CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DEL CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DEL CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DE LA CONT	10	19	10					

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		•	For State Registrer	Otate of it	nar y tar i	•	tificate of L		i i i i i i i i i i i i i i i i i i i	_	2005	31,21,8
			Decedent's Name (First, Middle, La	st)					2. Date of D	eath		3. Time of Death
ı	Physicia /Medic		Doris Arvella Jo	hnson					Octobe	л 6,		6:30 A M
	Examin		4a. Facility Name (If not institution, giv				4b. City, Town, or	. County of Deat	h			
			Calvert Manor He 5. Social Security Number 6. S			ast birthday)	Rising If Under 1 Year		Cecil			
	Funeral Director		073-14-1551 Usual Residence of Decedent	M 2ÅF	84	Yrs.	Months Days	If Under 24 Hr Hours Min		y, Year)	1921 g. Bin	hplace (State or Foreign untry) PA
	land ow	1	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary 9-1 sh	tor	MD Cecil		R	ising:	Sun					1 ☐ Yes 2 No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?
	eth wi	rai	1881 Telegraph				21911				SA	
	er de Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2X	\$?	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, White	
920	urs aft	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates			I□Yes 2□XNo	Specify:			Specify: Wh.	ite
o Q	filed within 72 hours after deeth with the Maryland Hygiene. ther then "netural", or tems 23s or 28s-f show snt, the Madical Examinal must to multified at	Completed	15. Decedent's E (Specify only highest gra			(Giva	lent's Usual Occupa kind of work done d	uring most of w	orkina	16b. K	ind of Business/	Industry
21	vithin ne. hen *	mpl	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. L	00 NOT use retired) retary		,	11	niversi	tu
, D	filed v Hygie ther t	Co	17. Father's Name (First, Middle, Last)		360	rerury	18. Mother's N	ame (First, Middle	1		cy
laŭ	ld be ental ked o	To Be	Jacob Eugene Tr						. Viola S			
Maryland 21215-0036	shou and M s mar		19a. Informant's Name/Relationship (19b. Mailin	g Address (Street a	nd Number or F	Rural Route Numb	er, City o	or Town, State, Z	tip Code)
	and 2 ealth m 27 I		Arthur D. Johns	on/son	COL D		1 N. Waln		and the second s			21911
ore	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If time 27 is marked other then "netural; or Items 23a or 28e-f show any injury or other treumetic event, the Madical Examinal must be natified at once.		20a. Method of Disposition 1 XBurial 2 Xcremation 3		9		sition (Name of natory or other place	l l	Date		ocation - City or	
Baltimore,	iit. Pa artmer ortent injury		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		Head		hristiana Name and Addres		10-2005			Delaware
Ba	Depa Impo any ii		Kichard }	Gor	ofie	1	. Name and Addres 11 S. Que	<u>en Stre</u>	et, Risi	ng S	nerak Hi un, MD	21911
	Physician		23a. Pan 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caus one cause on each	edithe death line.	i. Do not enti	trokes	g, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or a	is a consequ	uence of):	HORES					Leare
K	Examiner	_	Sequentially list conditions.	b. Due to (or s	is a consequ	ionac of):						
1.7	tuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5	is a consequ	261100 01).						
760, 2	ires that the death certificate be exec pled signed by the attending physician and dibe detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or a	is a consequ	ience of):						
∞ −	cate be	dicai	•	d								
9 X	certific iding p	by Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	ncy					23d. Date of deli	N/PD/
Box	leath atten	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pregnancy Other (specify)			- 1	Month Month	Day Year
P. O.	t the c by the tached	hysi	9 Unknown	9□ Unknown								
Ś	Physicien: The law requires that the death certifica this certificate has been signed by the attending praid director, page 2 should be detached for use as the	by P	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying cause give	n in Part I.				the cause of death?
ord	w requir been s should	eted	spilepsy						14	Yes 2	Olo 3□Pro	obably 4 Unknown
Record	e law has b	Completed							24a. Was	an psy ormed?	24b. Were au prior to death?	topsy findings available completion of cause of
a	certificate ha		OS Was once referred to medical						1 Yes	2 No		2 🗆 No
Vital	s certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatien	t 3 DOA Othe	~	eath (Check only Home 5 Res		6 □Other (Spec	ify)
اه ر	iding Physicien: th: After this certifical funeral director, i	—	27. Manner of Death	28a. Date of Ir (Month, L		28b. Time of Injury	28c. Injury Work		28d. Describe			
sior	Attending is death.	atio	2 Accident 5 Pending investigatio	n	, , , ,	,		es 2□No				
Division of	I or Attendated after death Director:	ertification:	3 Suicide 6 Could not be determined	28e. Place of I building,	njury - At ho etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To			ral Route Number,
_	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	O	29a. Certifier 1 Certifying Pl	nysician: To the bearinger: On the basis	st of my know	wledge, death	occurred at the tim	e, date and plac	ce, and due to the	cause(s)	and manner as	stated.
	To the H within 24 To the F complete	Medicai										
1	Wil To	_	A A O	1			1	SC 92	ا م			62000
	7	,	30. Name and address of person who	completed cause of	f death (Item	23a) (Type	Print)	/2 8 2 S	2	Ud	LD WELL	6,2005 6,2005 1,1005
	~		WEIL E. LAT	TIW, N	W	101	Cow	WIAL	Way.	Ris	ing Su	1 MO 21911
	Sta Registr		31. Date filed (Month PO, Tea) 7	2005 32. R	strar's Signat	ture	hast.		λ.)	

			For State	State of Ma			ent of H		d Mental		11115	34249	
			Registrar 1. Decedent's Name (First, Middle, Last)			er unce	ate of L	Jeani	2. Date o		riog. No.		
П	Physici		Jacinth F	aith Joyr	ner				Month	Da	30, 200.		
	/Medic Examin		4a. Facility Name (If not institution, give s		101	4b. Ci	ty, Town, or	Location of D		4c. County of Death			
	Exami	•	12506 Montclair Dr	ive		Si	lver S	Spring		Montgomery			
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birtho	Month		If Under 24 Hours	Hrs. 8. Date of (Month	f Birth , Day, Year	9. Bir	thplace (State or Foreign	
	Director		579-76-6921 Usual Residence of Decedent	W 281	51 Yrs	S.			Jan.	14,19	954 Jam	aica	
	ow ow		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits	
	Many many iffied	tor	Maryland Montgomer	y	Silver	Spri	ng					1 🛣 Yes 2 🗆 No	
	or 28	Director	10e. Street and Number				Zip Code				itizen of What C		
	ath w	ral	12506 Montclair D					20904			ted Sta		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a Marical Examiner must be mutilised at	by Funeral	11. Marital Status 1 □ Never Married 2気 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		If Yes, s	cedent of Hi pecify Cubar 2 2 No	spanic Origin n, Mexican, P Specify:	? (Specify Yes o Puerto Rican, etc	r No-	14. Race - Ame Black, Whi Specify: B	te, etc.	
21215-0036	2 hou atura	ted	15. Decedent's Educ	eation	16a. D	ecedent's U	sual Occupa	ation		16b. I	Kind of Business	/Industry	
215	thin 7. e. an "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5		fe. DO NO	work done d use retired,	luring most of)	t working				
2	ed wi	Con	12th		Ent	repre	neur				Private		
Maryland	be fill htal H ed oth	Be	17. Father's Name (First, Middle, Last)						Name (First, Mi		n Sumame)		
2	hould d Mer marke	2	Edgar Holness 19a. Informant's Name/Relationship (Tyx	ne Print)	19h M	tailing Addr	ass (Stroot a		leen Her		or Town, State,	Zin Codel	
a S	id 2 s lth an 27 Is r traur	1	McKinley Joyner, I		1				,Silver	-		20904	
ē,	s 1 an f Heal ltem 2		20a. Method of Disposition		20b. Place of D	isposition (f	lame of or other place	a) I	Date	20c. L	ocation - City or	Town, State	
altimore,	Page nent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Gate of	•			. 7, 200	5 Si	lver Sp	ring, MD.	
Balti	permit. Pages 1 am Department of Heali Important: If Item 2 any injury or other once.		21. Signature of Funeral Service License	DO.D.	200	22. Name	and Addres		Pope Fu	neral	od Drive	20904	
			23a. Part1. Enter the disease or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not	enter the m	ode of dying	g, such as car	rdiac or respirato	ry arrest,	8, 111/1	Approximate Interval Between	
	Physician	0.1	Immediate Cause (Final disease or condition		ary Embo							Onset and Death	
	/Medical Examiner	- 1	resulting in death)		a consequence of)								
	LAdimilei	7	Sequentially list conditions, b		a consequence of).								
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Ulasassa or injury	Due to (or as	a consequence or								
	execunand and all-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as	a consequence of):								
8760,	icate be executed physician and s the burial-transit	dical	d										
9	± 50 €	(D)	IF FEMALE:										
Вох	es that the death certification of the attending for the detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal death	3 ☐Ectopic 5 ☐ Other				_	23d. Date of de Month	livery Day Year	
P.O.	at the by the tache	hys	9 🗆 Unknown	9□ Unknown									
	w requires the been signed should be de	by	Part II. Other significant conditions con Type 1 Diabete	_	_	ne underlyin	g cause give	en in Part I.				o the cause of death?	
Records,	The tarate has	Completed							- 8	Vas an lutopsy performed? es 2 □ No	prior to death?	utopsy findings available completion of cause of 2 No	
Ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						Death (Check o				
<u>5</u>	d is	2	1 🛱 Yes 2 🗆 No	ospital: 1 ☐ Inpatie			DOA Othe	or: 4 🗆 Nursin			6 ☐Other (Spe	cify)	
UC.	ding F	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Da)	Year) 28b. Tim Inju		28c. Injury Work	at :? /es 2.⊟No		ibe how inju	ury occurred		
Division of Vital	tten deatl stor: the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ıry - At home, farm					on (Street a	nd Number or R	ural Route Number,	
2		Certification:	4 Homicide	building, etc	. (Specify)	,,	,		City or	Town, Stat	(e)		
	To the Hospital within 24 hours and To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin		examination and/o								
	To the within To the Comple	Me	29b. Signature and title of confider	7,00)		29c. License	number		29d. Da	ate signed (Mont	h, Day, Year)	
			1/15	MAA			D4547	71		0ct	ober 6,	2005	
)	121		30. Name and address of perso who co	pleted cause of d	eath (Item 23a) (Ty	rpe, Print)							
		2	Yeheyis Negussie 31. Date filed (Month, Day, Year)	M.D. 1	111 Spri	ng St	. Suit	e 214,	Silver	Spri	ng, MD.	20910	
	Sta Registr		OCT 0 7 2005	Such	ar's Signature	and I							

210

05-06784 Kuczma, Jan D. **Physician** /Medical Examiner **Funeral** Director Maryland or 28a-f shov Examiner must be notified at Иете 23а death filed within 72 hours after Baltimore, Maryland 21215-0036 ò "natural" The Medical then

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Jan David Kuczma, II 5, 2005 October 0 2:18 PM 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Route 194 and Coppermill Road Woodsboro Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 215-05-2505 34 Yrs. November 1970 Washington, D.Q Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 THO Directo Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12020 Warner Road 21757 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 THO 1 Never Married 2 Married 1□Yes 2□No f Yes, Give Year or Dates: Specify. white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Student 12 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jan David Kuczma Nan Todd ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nazire Uen-Kuczma - wife 12020 Warner Road, Keymar, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glade Cemetery 10-10-2005 Walkersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatu of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 SALAKON Me 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple disease or condition resulting in death) Muries Due to (or as a consequence of) Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury Directo (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

124 Yes 2 No 24a. Was an

Physician /Medical Examiner

attending physician and for use as the burial-transit

other

permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked eny injury or other treumatic song injury or other treumatic song in

12 should be fill h and Mental H 7 ie marked oth

other treumatic event,

Examine Physician/Medical þ Completed Be ٩ Certification;

or Attending Physician: The law requires that the death certificate be executed

this After thi

filled in by

Medical

death. Director: A

within 24 hours after To the Funerei Dire

Box 68760

Division of Vital Records, P.O.

29a. Certifier

25. Was case referred to medical 1XXes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide

Hospital: 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 10-5-05

2 ER/Outpatient 3 DOA 28b. Time of 4:44 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Dotter (Specify) Scene 28d. Describe how injury occurred a motorc involved in an accident

autopsy performed? 1 Yes

26. Place of Death (Check only one)

2 No

28f. Location (Street and Number or Rural Route Number, City of Town, Stafe) Route Stafe and Cuppermill Roed 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

October 6, 2005

29b. Signature and title of certifier

29c. License number **OCME**

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

a Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

State Registrar 31. Date filed (Month

State of Maryland / Department of Health and Mental Hygie 0 0 5 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death **Physician** Month Year 53 65 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMIC 40Ur If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Number 7. Age (In yrs. last birthday) **Funeral** Days Min MM 2DF 68 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiane. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exarcit and must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No MD Worcester Berlin Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11647 Beauchamp Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Refrigerator and Elementary/Secondary (0-12) Coltege (1-4or 5+) Air conditioning repair 0wner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Kemp Katie Creasy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katie Griffin 70 Sandyhook Rd., Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 110-7-2005 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Somura Funda Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DIVYHOSTS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 2U No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death | Check only one Hospital: 1 patient 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Mapher of Death Natural 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D26278 30. Name and address of person who completed couse of death (Item 23a) (Type, Print) Po Box 1733 Solist Calpu State Registrar

		-	For State	State of Marylan		artment			ınd Me		-	2005	210) i
			Registrar 1. Decedent's Name (First, Middle, Las	1)	Cei	runcau	OIL	Jeani	1 2	Re 2. Date of Death		2005	3. Time of	Death.
	ysicia	n	Mary R. Keller	•						Month October	Day	2005	4:22	200
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	neral		5. Social Security Number 6. Se	7M 2€7F	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,		Cou	place (State or untry)	
	ctor		292-24-6461 Usual Residence of Decedent	88	113.				F	eb. 8,	191	7 West	Virgi	nia
nylan	H T	-	10a. State 10b. County		, Town or Lo								10d. Inside Cit	
he Ma	office	octo	Maryland Anne Ar	rundel Ani	napoli								1 🗌 Yes	2. K.] No
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re, N s 1 and f Heelth Itam 27	th.	-	20a. Method of Disposition	20b. P	ace of Dispo emetery, crer				Dat			ation - City or T	own, State	
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thatt			Part II. Other significant conditions co	entributing to death but not resu	ılting in the u	nderlying ca	ause give	n in Part I.		23e. Did toba	acco us	e contribute to t	the cause of de	ath?
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Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes	d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory	, office		28	f. Location (Stre City or Town,		Number or Run	al Route Numb	oer,
To the Hospital Within 24 hours a	letely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Madical Exam	vsician: To the best of my knowinar: On the basis of examinat and manner stated.	wledge, death ion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, and h occurred	d due to the cau	use(s) a le and p	nd manner as s place, and due t	stated. to the cause(s)	
To th within To th	comp	Me	29b. Signature and title of certifier	hanon	y n	-	License		010			signed (Month.	Pay, Year)	
			30. Name and address of person who cold 4300 GALLA			Print) 2 2	Bov	VIE	M	1) 20	71	5 D	CAKESH	ARORA
Re	Stat	G	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Should	8 0							

State of Maryland / Department of Health and Mental Hygiene Reg. 86. 00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9,_ Edward Theodore Kurtzner 2005 12:05 P M October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 66 Hacks Point Road Earleville Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 014-01-1023 Yrs. Director 88 AUG. 17, 1917 Massachusetts Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show the Woolcal Exampler is that be notified at 1 ☐ Yes 2 ☐ No Director Maryland Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Hacks Point Road 21919 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed withIn 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: White ģ 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Technician Research permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 27 Is marked othnery injury or other traumatic event, sock. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward T. Kurtzner Ethel Ostberg 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph S. Wolf/Personal Rep. 7660 Blackhawk Road, Micco, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date October 10, 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) R.A. Ferris & Co., West Chester, PA Inc. 2005 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause operatch line. 22. Name and Address of Facility 21921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) I □ Yes Ö 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 2 No 1 ☐ Yes : After this certification at the things of 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Special Pregivers 1 Yes 2 No ² 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident I Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ally NL 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Barbara A. Parey M.D. M.D. 11 W 32. Registrar's Signatur West High Street Suite 214 Elkton, MD 21921 31. Date filed (Month, Day, Year) **OCI 1** 1 2005 State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 34254 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3 12:30 P BRENDA LEE KAUFFMAN KINDRAT OCT 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE 100 CREEK POINT ROAD CENTREVILLE If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Yrs. SEPT.12,1958 MARYLAND Director 217-74-7036 47 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Examiner must be notified at 1 Yes 2 No QUEEN ANNE MD CENTREVILLE Completed by Funeral Director the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 Iteme 23a 100 CREEK POINT ROAD 21617 USA Pages 1 and 2 should be filed within 72 hours after death nent of Heatih and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Iteme 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. ☐Yes 2XNo 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INVESTIGATOR 12 U.S.D.A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM H. KAUFFMAN DOLORES MOWERY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES KAUFFMAN/ MOTHER 4355 S. PENINSULA DR., PONCE INLET, FL 32127 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10-5-2005 STEVENSVILLE, MD permit. Page Department of Important: If eny injury or once. * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown sate has been signed page 2 should be de Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 No rs after deau...
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in by the funeral director, pe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral L 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signatu and title of centrier cause of death (Item 23a) (Type, Print) 29466 PINTAIL DRIVE, SUITE 5, EASTON, MD 21601 DAVID H. SMITH, M.D., 32. Registrar's Signature State 2005 Registrar

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v X	Physicia		Decedent's Name (First,	Middle, Last)						2	Date of Deati Month	Day	Year	3. Time of	
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	Examin	er	4a. Facifity Name (If not ins Sacred	Hear	t Hosk	ital		Cum		nd			legar		
	Funeral Director		5. Social Security Number 212-78-516	6. Sex	7. A	ge (In yrs. la 48		If Under 1 Y		24 Hrs. 8. Min.	Date of Birth (Month, Day, Oct 16,			place (State o ntry)	r Foreign
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21215-0036	d within 72 hours after death with the Maryland plane. Than "natural", or Items 23a or 28a-f show the Medical Examinal mast be neithed at	Completed	15. De (Specify only	cedent's Educ highest grade	cation completed)		(Give	tent's Usual O kind of work of DO NOT use r	one during most	of working		6b. Kind o	of Business/Ir	ndustry	
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Tiffeny Ketterman deughter 412 Arch Street Cumberland MD 21													2		
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OU	Attending I r death. ector: After by the funer	tlon	Natural 5	Pending investigat:on	(Month, D	ay Year)	fnjury	м	Work? 1 ☐ Yes 2 ☐ I			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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۵	To the Hospitel or Attending Phwithin 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical Cer	29a. Certifier (Check only one)	ertifying Phys edical Exemi	sicien: To the bes ner: On the basis and manner s	of examination	rledge, death on and/or in	n occurred at t vestigation, in	he time, date and my opinion, deat	d place, and th occurred	d due to the ca at the time, da	use(s) and te and pla	I manner as s	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of	certifier				29c. L	cense number		25	d. Date si	gned (Month,	Day, Year)	
				len	w/)			D	2124	4		101	14/6	2005	
	4		30. Name and address of Ar. Jesus	oerson who co	0701 Ne	death (ftem	23a) (Type,	erint)	ek Rd	Fros	thurg	M	aryla	nd 21	532
13 m	Sta Registi		31. Date filed (Month, Day	1 200	Elawa.	trar's Signati	dos.	Les .		,	(,	1		

			i icase i	State of Maryla				-	giene	•
		•	For State Registrar	State of Maryla	•	rtificate of		_	Rog. N2 0 0 5	31,256
	0		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	hysicia /Medic		Doris An	n Kirk				DC 10BEN	- /3 200	
	xamin	er	4a. Facility Name (If not institution, give s			4b. City, Town, o	and the second		4c. County of Do	
			Calvert Manor He	ealthcare L	Enter s. last birthday)	Ris If Under 1 Year	If Under 24 H		Cec	
	ineral ector		5. Social Security Number 6. Sex 12 - 32-4652	7. Age (m yr	76 Yrs.	Months Days		Ain. 8. Date of Bir (Month, Da	y, Year)	Birthplace (State or Foreign Country)
D			Usual Residence of Decedent					100,42	7,1525	
arylar	show	_	MD Cecil		City, Town or Le	40				10d. Inside City Limits 1 ☐ Yes 2 X No
Me M	28e-4	ecto	10e. Street and Number		1/21	ng Sun			10g. Citizen of What	
with	3e or	2		ph Road			21911		U.S	
death	E DIE	Funeral Director		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	fispanic Origin?	(Specify Yes or No Jerto Rican, etc.)	14. Race - A	merican Indian,
36 safter	or le	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 X No	Specify:			Nhite
21215-0036 od within 72 hours afl	furel al Ex	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Occur	pation		16b. Kind of Busine	
215 hin 72	Modifical Modifical	plet	(Specify only highest grade		(Give	kind of work done DO NOT use retired				nications
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	at the	Completed	12		Te	lephone				nicacions
be (ii)	even even	Be	17. Father's Name (First, Middle, Last) A. Rogers	K:+k		·		Name (First, Middle,	Maiden Sumame) Prton	
Maryland d 2 should be file th and Mental Hy	mark	은	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Street			er, City or Town, State	a, Zip Code)
e, Ma 1 and 2 s Health ar	27 ls r treu		John Kirk.			Route 681		Marshfie		15766
or He	r othe		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ R	20b	. Place of Dispo cemetery, cre.	osition (Name of matory or other place	ce)	Date	20c. Location - City	
Pag ment	lury o		'4 □ Donation 5 □ Other (Specify)	, ,		Cremata		t. 14,2005		
Baltimore,	Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examinational bandlind at once.		21. Signatur ineral Service License		2:	2. Name and Addre	Street	dward L. Co	d, PA 15	Home, inc. 363
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the de le cause onteach line.	ath. Do not en	ter the mode of dyir	ng, such as care	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition resulting in death)	DEMONTIA	- AUSH	amens Ty	P€			2 YRS.
	edical miner		resulting in death)	Due to (or as a cons	equence of):					
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consi	өциөпсө of).					
petno	ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
760, te be executed	ysician and he burial-transit	EX	resulting in death) Last	Due to (or as a cons	equence of):					
687	physics s the t	edlcal	d							
Box 6	igned by the attending physician be detached for use as the burial	n/Me	IF FEMALE: 23b. Was decedent pregnant 2:	3c. If yes, outcome of preg		75-4			23d. Date of d	delivery
Geath	ed for	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.O	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions con		esulting in the u	nderlying cause gry	en in Part I	23e. Did t	obacco use contribute	to the cause of death?
Records, P.O. Box 68 The law requires that the death certifica	ergre d be	d by	Fait II. Other significant conditions con	mindting to add to but hot h	esuling in the u	nderlying dadde giv	on mi arti.			Probably 4 DUnknown
Records,	s paen si should	Completed						24a. Was	an 24b. Were	autopsy findings available
Re la	certificate has t irector, page 2 s	omp						autop perfo	osy prior t ormed? death 2∕2 No 1 □ Y	
	director, p	BeC	25. Was case referred to medical examiner?				26. Place of I	Death (Check only o		
, je	a this	မှ	1 ☐ Yes 2 No	ospital: 1 Inpatient 2		and the same of th	Nursin		dence 6 Other (S)	oecify)
on ding	After	tlon	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat K? Yes 2 ∐No	28d. Describe	how injury occurred	
Division I or Attending after death.	ector; by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At building, etc. (Spe	home, farm, st	reet, factory, office		28f. Location (Street and Number or	Rural Route Number,
Div tel or	ed Dir	Cert	4 Homicide	building, etc. (Spe	City)			City or You	vii, State)	
Division To the Hospitel or Attending within 24 hours after death.	To the Funerel Director: completely filled in by the	Medical		nicien: To the best of my k ner: On the basis of exami and manner stated.						
To the	o the	Med	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
F 51	. 0		Drown Der			HSE	3419		OcroBin 13	,2005
	2		30 Name and address of berson who co	mpleted cause of death (It	ет 23a) (Туре, ГИСКА Р	Print) H ROAM.	RISING !	SVN, MD		1
	Sta	te	31. Date filed (Marth Day, Year) 2 1 2005	2. Registrar's Sig	nature		3 4			
The Land	Registr		061 & 1 2005	Blocke B	Apen	W.				

		For Stata Registrar	State of	Maryland		artment of He rtificate of D		-	giene 0 (05	34257
Physi		Decedent's Name (First, Midd Viola	M.	Lewis		*		2. Date of De Month	ath Day	Yeer	3. Time of Death
/Med Exam		4a. Facility Name (If not institution		oer)		4b. City, Town, or L	ocation of De		6,2005 4c. County		7:30 P
		SALISBURY REHA	B & NURSIN	G CENTE	R	SALISBURY			_1	MICO	
Funera Directo		5. Social Security Number 222–09–5095	6. Sex 7. 1 ☐ M 2 1 F	. Age (In yrs. Ia 88	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	1rs. 8. Date of Bin (Month, Da 3/15/1	917	9. Birthpla Countr Dela	ace (State or Foreign y) Ware
pue *		Usual Residence of Decedent 10a. State 10b. County	,	10c. City.	Town or Lo	cation				10	d. Inside City Limits
Manyti f sho	Ď		omico	W	illard	s					Yes 2 No
h tha	Director	10e. Street and Number	J200			10f. Zip Code			10g. Citizen of V	What Counti	ry?
ath wit		Pine	St.			21874			USA		
be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23e or 28e-f show event, the Medical Examinational bandlind at	/ Funeral	11. Marital Status 1 Never Married 2 Mar	If Yes, Give	es? XNo		Was Decedent of His f Yes, specify Cuban, 1 □ Yes 2€ No	panic Origin? , Mexican, Pu Specify:	' (Specify Yes or No Jerto Rican, etc.)	14. Rac Blac Specify	e - America ck, White, et	
72 hours natural',	od by	3 XWidowed 4 □ Divorce	Year or Dat	es:	16a Dece	ient's Usual Occupat	ion		16b. Kind of Bu		
be filed within 72 hc tal Hygiena. d othar than "nature evant, the Medical	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4	lor 5+)	(Give life. i	kind of work done du DO NOT use retired)	iring most of u	working	Shirt E		,
filed v Hygie thar t		11. Father's Name (First, Middle	Last)		Tusp	ector	I8. Mother's N	Name (First, Middle,			
an y raite 4 1 2 2 should be filed with and Mantal Hygiena 18 marked other their aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years aumatic event, the years are years and years are years.	To Be	Harvey Hudson					Prisc	illa Morr	is		
C, INC. JIC. 1910 1 and 2 should 1 Haalth and Man itam 27 is marke other traumatic		19a. Informant's Name/Relation Donald L. Lewi			19b. Mailir 3626	ng Address (Street ar O Pine St	., Wil	Rural Route Number lards, MD	or, City or Town, 21874	State, Zip C	Code)
Pagas 1 and the nant of Haunt: If itam		20a. Method of Disposition 1 Burial 2 Cremation		ate Wice	metery, crer DM1CO	sition <i>(Name of</i> natory or other place) Memorial	10	Date /11/05	20c. Location -	-	
2 5 E E E	ODC8.	4 □ Donation 5 □ Other (3		Pai		Name and Address	1				
	a	23a. Part1. Enter the disease, of	r complications that cau	ise the death	5	Ol Snow Hi	11 Rd.	., Salisbu	ry, MD	21804	Approximate
Physicia	n	Mock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause on ear	Leene	ŧ	Dane	of ca	> -		1	Interval Between Onset and Death
/Medica Examine		resulting in death)	Due to (o	r as a consequ	ence of):	,			-		
pg is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	r as a consequ	ence of):	,					
cata ba axacutad physician and tha burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or	r as a conseque	ence of):	e e					
cata ba physicia tha bu	dical		d								·
The law requires that the death certificate be executed the law requires that the death certificate be executed at a been signed by the attending physician and page 2 should be detected for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ome of pregnan th 2 D Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)				te of delivery	y Day Year
that the dated by the datached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		u 0_	J Cities (apocity)					
uiras tha signad I	by	Part II. Dther significant condit	ions contributing to dea	th but not resu	lting in the u	nderlying cause given	in Part I.				cause of death?
a law requir has bean si	Completed							24a. Was autop	SV D	Were autops prior to comp death?	sy findings available pletion of cause of
	e Co	25. Was case referred to medical					OS Blace of F	1 Tes	2 No 1	1 ☐ Yes 2	No No
ysicia s carti diracto	0	examiner?	Hospital: 1 🔲 Inj	patient 2 🗆 E	ER/Outpatier	Othor		Death (Check only of g Home 5 ☐ Resid		er (Specify)	
ding Phys h. Aftar this funaral di	atlon; T	27. Manne eath 1 atural 5 Pendi 2 Accident invest	28a. Date of		28b. Time of Injury	28c. Injury a Work?	at		now injury occurr		
or Attanding Physician: I or Attanding Physician: after death. Diractor: Attar this cartific I in by the funeral diractor.	Certifica	3 Suicide 6 Could	not be 28e. Place o	f Injury - At hor g, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Numb m, State)	er or Rural i	Route Number,
To the Hospital or Attanding Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce	(Check only 2 Medica	ng Physician: To the b	is of examinati	viedge, deati on and/or in	n occurred at the time vestigation, in my opi	, date and pla nion, death or	ace, and due to the courred at the time,	cause(s) and ma date and place, a	inner as stai	ted. he cause(s)
o the ithin 2 o tha omplat	Med	one) 29b. Signature and title of certifi	and manne	n StateO.		29c. License	number		29d. Date signed	d (Month, D	ay, Year)
⊢≯⊨ŏ		1	11			02	-17	88	10/11	100-	
		30. Name and address of person	who completed cause	of death (Item	23а) (Туре,	Print)			1	V.	
		WILLIAM ROBIN	S, M.D. 200	CIVIC	AVE.,	SALISBUR	Y, MD.	21804			
S Regis	State strar	31. Date filed (Month Car Yea	1 2005	gistrar's Signati	I A	barke					

			For Amend It	emState paMary	land,/depe Cer	inmentuelde	eaith and N Death	ental Hygie	2005	34258
	00		Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Death
	Physicia /Medic	al	Gary Thomas I	abuwi		4h City Town or	Location of Death	October 1	15, 2005	9:30 А м
ı	Examin	er	3818 Prospect F	Road		Street			Harfo	rd
i	Funeral Director		213-50-6561	ex 7. Age (In 50 50	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Mar. 14,	9. Bi	thplace (State or Foreign ountry) ryland
	and w		Usual Residence of Decedent 10a, State 10b, County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Manyl f aho	ō	MD Harford	1 I	Street					1 ☐ Yes 2 📆 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	th with		3818 Prospect B	Road		211!	54		U.S.A.	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ahow aumatic event, the Madical Examiliar must be nutified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	te, etc.
Ş	2 hours	d par	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E		16a. Deced	lent's Usual Occupa	ation	. 16	b. Kind of Business	
Maryland 21215-0036	ithin 72 nan "nan	Completed	(Specify only highest gra	College (1-4or 5+)	life. L	kind of work done of DO NOT use retired cering Tec) -		ivil Serv	ice
2	illed w Hygier ther th		12 17. Father's Name (First, Middle, Last,	0	шідті	ering re		e (First, Middle, Ma		
an	ld be fental i	To Be	Lewis Royal Lab					ol Lankaı	·	
ary	should I	-	19a. Informant's Name/Relationship (Турө, Print)				al Route Number, C		Zip Code)
	and 2 ealth a n 27 is		Gena Labuwi (Wi			Country V			Air, MD	21014
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State (y)	Harford M	natory or other plac 1em. Gdns	10/19	0/05 Ak	c. Location - City o perdeen,	
Bail	permit. Departr Importa any inji		21. Signature of Funeral Service Licer	Bollmar) At	perdeen, 1	Maryland	ral Home, 21001-33	399	
Г			23a. Part1. Enter the disease, of com- shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
ľ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. My CAL Due to (or as a co	DIAL INF	CRETISA				2 HOURS
	Examiner		O	bue to (or as a co	risequerice or).					
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of);					
_,	rcate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):					
8760	te be e ysiciar ie buri	dlcal	(d						
9	rtifica ng ph	0	IF FEMALE:						1	
Vital Records, P.O. Box	The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	vlivery Day Year
ري ت	s that ned b e deta	y Pr	Part II. Dther significant conditions	contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute	o the cause of death?
g	w requires that been signed to should be det	ed t	MASERIENZION					1 ☐ Yes	2 2 No 3 □ F	robably 4 Unknown
Reco	The faw re cate has be page 2 sho	Completed						24a. Was an autopsy performe 1 Yes 22	prior to death?	utopsy findings available completion of cause of s 2 No
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					th (Check only one)		
0	Phys this al dil	10	1 XYes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4 🗀 Naising III	ome 5 Residence 28d. Describe how		ecify)
on	Attending Physician: r death. ector: After this certifics by the funeral director, I	tlon	1 ≦Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	Worl	Yes 2 □No	280. Describe now	lillary occurred	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		At home, farm, str specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or F State)	tural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the funeral or the form of the funeral or the funeral o	Medical C	29a. Certifier t Certifying Pl	nysician: To the best of m miner: On the basis of exa and manner stated.	mination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau- red at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
	vithin To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	29d	l. Date signed (Mon	th, Day, Year)
			Philip W. Holst	ach rao		0208	93	1	5/17/05	
			30. Name and address of person who				A A 1	1.45		
	Sta	ite	31. Date filed (Month, Day, Year)	_32. Registrar's	Signature	HE JOULEAN	ar , ho L	1011		
***	Regist		OCT 2 4 2005	Dine .	1 America	20		arph.		
	IMH 17 Pay 1/2			8	27	200				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 205 34259 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 **Physician** October 8, 5:50 PM Levenbook /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery 5100 Dorset Avenue #308 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye)
Dec 29, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 85 Japan Director 162-30-9182 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!, or items 23a or 28e-1 show any injury or other traumetic event, the Macdical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5100 Dorset Avenue #308 USA 20815 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2K No Yes Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Biochemist Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rikki Umanskaya David Levenbook 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5100 Dorset Avenue #308 Chevy Chase, MD 20815 Alessandra L. Levenbook/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 10, 2005 Odenton, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Ly L MO1251 Beverly L. Heckrotte, P.A. Clarksyille, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atheroso leron ean /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe o 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 2000 2 No or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After SNatural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 (Item 23a) (Type, Print) Name and address of person who completed cause of death

Registrar

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State of Maryland / Department of Health and Mental Hygiene20051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 1408 M Octobe. 2005 Ponar 1510 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore maryland Baltimore Johns Hopkins Bayview If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 28, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 20XF Months Days Hours Yrs. 1940 New York Director 64 118-32-3299 Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, its Madical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 USA 5453 Hound Hill Court deeth y 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. a filed within 72 hours after if Hygiene.

Other then "natural", or itel 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ♥ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Librarian Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health end Mental I shout: If item 27 is marked or Evangeline Smith Isaac Aikens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gladys A. Spencer/sister 8994 Wetbanks Court Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 8. 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) 2005 Arundel Crematory Odenton, Maryland 22. Name and Address of Facility Going Home Cremation Service 21. Signature of Funeral Service Licensee P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death and Death Immediete Cause (Final 5 **Physician** ays SEPSI resulting in death) /Medical Due to (or as a consequence of): Examiner fungemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner miltiple The law requires that the death certificate be executed physician and the burial-transit iny eloma that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed? certificate 1 Yes 2 No To the Hospitel or Attending Physicien: After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral (29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) RES-000 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Wolfe Street Bulfimore Manyland ND 600 Kober + HOESUL 31. Date filed (Month, Day, Year)
OCT 1 1 egistrar's Signature 32. State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:23 Linthicum October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9510 Gas House Pike Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | 1940 | Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Months Director 215-36-3676 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 Is marked other than "neturel", or Itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Maryland Frederick Frederick 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9510 Gas House Pike 21701 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give I Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Itan eny injury or other traumatic event, the Medical Everthern once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) cabinet maker cabinetry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sophie Carlisle Charles H. Linthicum, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 9510 Gas House Pike, Frederick, Maryland R. Marie Linthicum - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect Cemetery 10-8-2005 Mt. Airy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 21702 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiovascular Disease heroscherotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner signed by the attending physician and d be detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate has page 2 1 🗌 Yes 2XNo or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Ti Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) the Street Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ZUUS Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Regulad Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Health & Rehab: Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Geomes Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days 1□M 25 F Hours 228-28-3332 ling Director Usual Residence of Deceder with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 17 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director Washington Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 12021 Livingston Road Funerai 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Exercising 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Baldwi Fannie Hudson amuel ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Mace Drive-Ft. Wishington, MD 20744
The of Disposition (Name of Date 20c. Location - City or Town, State Hazel Hayes Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 8,2005 L * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Notional Cen aurel, Maryland 22. Name and Address of Facility Greene Funeral Home, INC 814 Franklin Street-Alexandria, VA 22314 21. Signature of Funeral Service Licenses nelson 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deeth 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 🗌 Yes 2 No Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Certification; To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours efter deati To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1년 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AXMIN, Berna 7700 old Branch Ave Suffictor - Clinton, MD 20735 31. Date filed (Month, Day, Year) 2. Registrar's Signature State OCT 0 7 2005 Registrar

			State of Mary	land / Den	artment of H	lealth and	Mental Hygie	ne S	
		1 - For State Registrar	State of Mary		rtificate of		weritai rrygiei	2005 34	264
		Registrar 1. Decedent's Name (First, Middle, I	Last)		Timeate of	Death	2. Date of Death		e of Death
Physic		Amie Long	,				Month	02,2005 9:0	Mg O
/Medi Examir		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of Deat		4c. County of Death	0 -
LAGIIII		Clinton Nursin	a and Rehai	h Cente	r Clint	on		Prince Georg	10
Funeral			. Sex 7. Age (Ir	n yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	9 Birtholace /Sta	te or Foreign
Director		216-32-6649	1□M 2 X F 83	Yrs.			Dec 31,1		
and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation			10d. Insid	e City Limits
Manyl 1 sho	ō	Md Dwings	Coorgo	1 0 0 0 0 0 0				120	'es 2 □ No
the 28a	Director	Md Prince 10e. Street and Number	e George G	lenarde	10f. Zip Code		10g.	Citizen of What Country?	
death with the Maryland ms 23a or 28a-f show rmat be notified at		1525 7th Stre	et.		20706		US	Δ	
death	Funeral	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of H	lispanic Origin? (S		14. Race - American Indian Black, White, etc.	,
or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specify:	
72 hours a	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:	10a Dana	double Herry Ocean	-ti-n	105	Black	
n 72 n	lete	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo d)	rking	. Kind of Business/Industry	
within than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ouse Wif			Own Home	
il Hyg other	0	17. Father's Name (First, Middle, La	st)				ne (First, Middle, Maid		
ld be denta	To B	Hudson Dicke	erson			Sammie	≘ E11a	Harris	
S ma	ļ-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Number, Cit	y or Town, State, Zip Code)	
and 2 auth n 27 l		Gracie Briggs		1525	7th Str	cet Gle	enarden_M		
partimore, Marylatic ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercities must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date 20c.	Location - City or Town, State	•
Dallillor Dermit. Pages Department of mportant: if it any injury or o		' 4 ☐ Donation 5 ☐ Other (Spe	city) I				t 11,05 I	Candover Md.	
Dermit Depart Import any in		21. Signate of Funeral Service Lic	ertee /) 2	2. Name and Addre	ss of Facility			
		yrone	2. vivees				719 Kenn		mata
		23a. Part1. Enter the disease, or/of shock, or heart failure. List on	ly one u e on each line.	de sin. Do not en	ter the mode of dyir	ig, such as cardia	or respiratory arrest,		Between nd Death
Physician		Immedia(e Cause (Final disease condition resulting in death)	a. ARRYTHE						
/Medical Examiner	П		Due to (or as a co						
	<u>ت</u>	Sequentially list conditions, if any, leading to immediate	b. ATHEROSO Due to (or as a co		Heart	diseas	e		
uted d ansit	Examiner	cause. Enter Underlying Cause Uisease or injury that initiated events							
execu in and ial-tra	Exa	resulting in death) Last	Due to (or as a co	ensequence of):					
death certificate be executed death certificate be executed eathending physician and defor use as the burial-transit	cal		d						
ntifica ng ph as th	Med	IF FEMALE:							
th cer tendir	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		Ectopic pregnancy	,		23d. Date of delivery Month Day	Year
. 0 00	Physician/Med	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	e of death 5[Other (specify)			Worth Day	1601
The law requires that the de ate has been signed by the sage 2 should be detached		Part II. Other significant conditions	s contributing to death but no	ot resulting in the r	nderlying cause giv	en in Part I	23e Did tobacc	o use contribute to the cause	of death?
signed the c	i by	•	renal dis	•	riderlying cause giv	SITHIT CITE.	1 ☐ Yes		
v requires been sign	Completed	_	Tenal Ols	ease					
e la has	ш	DEMENTIA					24a. Was an autopsy performed	24b. Were autopsy findin prior to completion of death?	if cause of
VICION: Thiconer The Contificate		OF Was assessed to madical					1 ☐ Yes 2 🔯	No 1 ☐ Yes 2 ☐ No	
OI VITAL Phyalcien: Tribis certifica	o Be	25. Was case referred to medical examiner? 1 Yes X No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or	ath <i>(Check only one)</i> Iome 5 ☐ Residence	6 DOther (Specific)	
oil of vital ding Physicien: th. After this certifica funeral director, p	1	27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe how in		
nding nth.: :: Afte	ation	1 XNatural 5 Pending 2 Accident investigat		ar) Injury		k? Yes 2 □ No			
Attendi	Certification:	3 Suicide 6 Could not determine		At home, farm, st.	eet, factory, office		28f. Location (Street City or Town, Sta	and Number or Rural Route N	umber,
rs after 5	Cert	4 - Homodo	Dallaling, did. (c				0.17 0.7 7 0.11.		
lospii hour uner			Physician: To the best of m					(s) and manner as stated. and place, and due to the caus	e(s)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Aedical	one)	and manner stated.						
To To	Σ	29b. Signature and title of certifier	1.CO. DH	9	29c. Licens	e mumber		Date signed (Month, Day, Yea	
(3)		- Justin	" Cufe	MD.	8820		Oct	ober 04,200	5
(3)		30. Name and address of person wh						0005	
Str	ate	106 Irving St. 31. Date filed (Month, Day, Year)	NW Suite 4	15 Sout	h Tower	Washir	igton, DC	20010	
310	rar	OCT 0 7 200		W down	AP 10				

			For State Registrar		State of	Maryla		artmen e <i>rtificat</i>			Mental H	ygiene ()	05	34265
	Physicia		1. Decedent's Name (First, M						-		2. Date of D	eath Day	Yeer	3. Time of Death
	/Medic		Dorothy		zabeth		iedy	1			Octob		2005	
	Examin	er	4a. Facility Name (If not institutions Manor						nberl	Location of Dea	ith	Alleg	ty of Death anv	1
	Funeral		5. Social Security Number	6. Sex	7		. last birthda) If Under	1 Year	If Under 24 Hr	s. 8. Date of B		9. Birth	place (State or Foreign
	Director		215-26-9418		M 21 ∑ F	90	Yrs.	Months	Days	Hours Mir	s. 8. Date of B Month D Jun 9	1915	Col	MB
	and		Usual Residence of Deceder 10a, State 10b, Co			10c. C	ity, Town or	_ocation				···		10d. Inside City Limits
	Maryl -f sho	tor	MD AI	legany			Cum	berlan	ıd					1 Yes 2 □ No
E	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28e-f show the Mcdical Examiner must be notified at	Funeral Director	10e. Street and Number					10f. Zip				10g. Citizen of		intry?
5	ath wi	rai	Seton Drive E					141 5		21502	01		SA	
工	items	-une	11. Marital Status 1 Never Married 2		Armed Ford	ces?	U.S. 13		1/	ispanic Origin? (in, Mexican, Pue	Specify Yes or N into Rican, etc.)		ack, White	
oro +	af, or	þ	3 Widowed 4 □ Divo		If Yes, Give Year or Da			1 🗆 Yes	2∐ No	Specify:		Spec	^{ify:} whit	te
O Y	72 hc	etec	15. Dece (Specify only h	edent's Educa ighest grade o	ition completed)		16a. Dec (Giv	edent's Usua e kind of wo	al Occupa	ation during most of w	orking	16b. Kind of	Business/Ir	ndustry
7 5	withln ene. than	Completed	Elementary/Secondary (0-	12)	College (1-	4or 5+)		ekeepe		"/		Holiday	Inn	
ر اط 2	be filed stat Hygi of other event, I	Be C	17. Father's Name (First, Mic					·····			ame (First, Middl			
y Sar	2 should be filed with and Mental Hygiene. Is marked other tha sumatic event, Ins M	ToE	Samuel Sh				1				(Hickle)	· · ·		
Liedy, Marylan			19a. Informant's Name/Rela Mary Reynolo	tionship <i>(Typ</i> e	daı	ughter	19b. Ma P.C	D. Box	301	and Number or F	Rural Route Num Ironia	ber, City or Town	ı, State, Zi NJ	07845
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremat 4 Donation 5 Other		moval from S	tate Su	Place of Dis cemetery, cr nset Me	osition (Nar ematory or o morial	ne of other place ark	e)	10/19/200	20c. Location 5 Cumbe		
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Ser	114	hil	M		108	3 Virg		ie: Cumbe		21502	2
			23a. Fart1. Enter the diseas shock, or heart failure.	e, or compilea List only one	ations that ca cause on ea	used the dea ch line.	ath. Do not e	nter the mod	le of dyin	g, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a.	Adv	ance	d	Dem						one year.
	/Medical Examiner		resulting in dealtry		Due to (c	r as a conse	quence of):							•
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (c	r as a conse	quence of):							
V	be executed sictan and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.										
8760,	be exectan a	ai Ex	resulting in death) cast		Due to (c	r as a conse	quence of):							
587	icate physics the	dica		d.										
Box 6	leath certifica attending ph I for use as th	In/Me	IF FEMALE: 23b. Was decedent pregnan		c. If yes, outc	ome of pregr		□Ectopic p	reanancy				ate ol deliv	•
Э. В	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	in the past 12 months? 1 ☐ Yes 2 🔼 No 9 ☐ Unknown			nt at time of		Other (sp				M	Ionth	Day Year
P.O.	that the de led by the a detached t		Part II. Other significant cor	nditions contr	ibuting to dea	ath but not re	sulting in the	underlying c	ause give	en in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
ds,	uires tha signed	d by									1 🗆	Yes 2□No	3 Pro	bably 4 Unknown
000	aw require s been si 2 should b	Completed									24a. Wa	s an 24b.	. Were aut	opsy findings available ompletion of cause of
a a	The law ate has page 2	Com									perl 1 ☐ Yes	ormed? 20 No	death?	2X No
/ita	clen: entific ector,	Be (25. Was case referred to me examiner?	-	enital:				Oth	7	eath (Check only	one)		
of \	ding Physicien: The In. After this certificate ha funeral director, page	- To	1 Yes 2 No 27. Manyer of Death	HO:			ER/Outpati)A	4 Nursing	Home 5 ☐ Res	how injury occu		fy)
o	th. : After	tion	1 Natural 5 □ Pe	ending vestigation	28a. Date of (Month	, Day Year)	Injury	м	28c. Injun Worl	k? Yes 2□No			47	
Division of Vital Records,	Attender death rector:	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place o	of Injury - At I	home, larm, s	treet, lactor	y, office		28f. Location City or To	(Street and Num	ber or Rur	al Route Number,
ō	itel or irs afte rel Dir lled in													
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, I	edicai				sis of examin					ce, and due to the curred at the time			
_	ro the within : го the	Mec	29b. Signature and title of ce	ortifier // -	0-					e number		29d. Date sign	ed (Month,	Day, Year)
			> work	LOGES	tun	MO)		#D	553	35	Oct 1	7,20	005
	1		30. Name and address of pe	rson who com	pleted cause	5 4		e, Print)		- 1		1.0	~	
900	2	••	Wonsock =	hin,	/ \(\)	gistrar's Sign	nature		ce	tros:	burg	MD	21	532
•	Sta Registr		0012	1 2005	Blake	ie d	1 de	West !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 055

34266

			For State Registrar	State of Ivialyte		rtificate of		-	leg. No.	0 4200
F	Physici	an.	Decedent's Name (First, Middle, Lass					2. Date of Dea Month	Day Ye	
	/Medic		Nellie E. Lowe			45 City Town	or Location of Death		4c. County of D	10:00 p
	Examin	er	4a. Fecility Name (If not institution, give Jacobs Well As		ina	Bel Ai			Harfo	
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yi	s. last birthday)	If Under 1 Year Months Days		8. Date of Birth		Birthplace (State or Foreign Country)
	Director		217 10 1001	□M 2□NF 88	Yrs.	Months Days	Hours Will.	8. Date of Birtl (Month, Day Oct. 10	,1917 N	Maryland
	and we		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl	ţō	MD Hari	ord B	el Air					1 □Yes 2% No
	or 288	Funeral Director	10e. Street and Number			10f. Zip Code	01015		10g. Citizen of What	Country?
	ath wi	rai	522 Thomas Rur				21015		USA	
	Hems Hems	nne	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	U.S. 13.	Was Decedent of his Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		merican Indian, /hite, etc.
	urs af	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: V	√hite
ה ה	be filed within 72 hours after death with the Maryland that Hygiene. Ind other than "natural", or items 23a or 28a-f ehow event, the Medical Exacifrar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra-	lucation de completed)	16a. Dece	dent's Usual Occup	pation during most of world)	king	18b. Kind of Busine	ss/Industry
Z	within ane. than	ldw	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire ISTRESS	d)		Cloth	ing
N 5	filed Hygie other		12 17. Father's Name (First, Middle, Last)						Maiden Sumame)	
land	Aental Aental rked tic ev	To Be	Harry Lowe				Ethe1	Scott		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any figury or other traumatic event, the Medical Exaction must be notified at ODCe.		19a. Informant's Name/Relationship (7) William S. Onic	Type, Print) on/Neighbor	19b. Mailir 512	ng Address (Street 8 Fawn	and Number or Ru Grove R	oad, P	r, City or Town, Stat y lesvill 21	e, Zip Code) e, MD 132
a,	of Head		20a. Method of Disposition 1 👺 Burial 2 □ Cremation 3 □		. Place of Dispo	natory or other ola	ca)	Date	20c. Location - City	
Ĕ	Page ment ant: If		'4 □Donation 5 □ Other (Specify	() P	entre resbyt	erian C	em. Oct	. 19,	New Par	
Daitimor	Depart Import any in		21. Signature of Funeral Service Licen	Kun	19	S. Mai	ess of Facility J. In St.,	J.Harte Stewar	enstein Estown,	Martuaty, In
,00/00	Physician and // Medical baseconed as the burnal-transit as the burnal-transit	al Examiner	23a. Part1. Enter the disease, or companies shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of): OSC 6 equence of):	usiow Errotic)VASCu	Im Disor	Approximate Interval Between Onset and Death
00	tificate ig phys as the	edlcal	-	d						
O. DOX	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
Cas, F.	quires that in signed by	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	1	e to the cause of death? Probably 4 Unknown
Records	as s	Completed						24a. Was a autop perfor	sy prior	
VII	ertifica octor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only of	TAXOE	SWELL TL
ō	Physician: this certific ral director,	Ţ.	1 ☐ Yes 20 No 27, Manner of Death		☐ ER/Outpatier 28b. Time o	IT 3LI DUA		ome 5 Resid	ence her (S	Specify) Luing
	Attending Physic death. sector: After this by the funeral di	tlon	Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year,	Injury	Wo	rk?]Yes 2 □ No	200. 5000507.	ow injury boodings	
DIVISION	of or Attendiated death. Director: A din by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str icify)	reet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate hy completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam and manner stated.	nowledge, deat ination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occur	and due to the o	ause(s) and manner late and place, and c	as stated. due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	Za- W	10	29c. Licen:	1011		29d. Date signed (Me OCTOBER)	
	4		30 Name and address of person who	RAVITEMO	56016	OCH RA	VENBIVE	BAITI	MURE MA	8,2005 RY/AND21239
*.	Sta Registi		31. Date filed (Month, Day, Year) OTT 2 1 2005	82. Registrar's Sig	gnature					
PALE		004		-	-					

DHMH 17 Rev 1/2001

		ricasc		d / Department of H		•	_	
		1 - For State Registrar	State of Marylan	Certificate of		Reg. No	'UUD	34267
Physic		1. Decedent's Name (First, Middle, La	Rernard	Moane	V	2. Date of Death Month Da	6,200	3. Time of Death 5 6:35 A M
/Med Exam		4a. Facility Name (If not institution, give			Location of Death		County of Deat	th
		110 third	Haven Heice	Sh+5 Fa	Ston If Under 24 Hrs.		Talbo	t
Funera Director		5. Social Security Number 6. S	DM 2 F 7. Age (In yrs.)	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Year (VOV. 30)		thplace (State or Foreign buntry)
D.		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location)		10d. Inside City Limits
Maryli -f sho	to	MD Talk	not	Easton				1 ☑Yes 2 ☐ No
death with the Maryland the 23a or 28a-f show	Funeral Director	10e. Street and Number	11	10f. Zip Code		10g. C	itizen of What Co	untry?
leath v ma 238	erai	1/0 Third	Haven He	13. Was Decedent of H	GO / Hispanic Origin? (Spec	cify Yes or No-	14. Race - Ame	arican Indian,
be filed within 72 hours after death with the Marylan tal Hyglene. Id other than "natural", or itema 23a or 28a-f showent. The Medical Examinar must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give	If Yes, specify Cub 1 ☐ Yes 2 12 No	an, Mexican, Puerto H Specify:	lican, etc.)	Black, White	e, etc.
2 hours	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's E	Year or Dates:	16a, Decedent's Usual Occur	pation	16b. F	Kind of Business/	ICK /Industry
within 72 ene. then "nai	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d)	1		
filed w Hygler ther th	Cor	17. Father's Name (First, Middle, Last,		Supervis		(First, Middle, Maide	<u>em: cal</u> n Sumame)	Company
uid be Mental Mental rrked o	To Be	William	Moaney		Anno	Levy	15	
VICE Sho h and !		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street				
re, r		20a. Method of Disposition		Place of Disposition (Name of emetery, crematory or other pla	. U	ate 20c. L	ocation - City or	rsey 07/03 Town State
CALLEMON TIME. Pages partment of portant: If I by Injury or or or or or or or or or or or or or		1 1 Burial 2 ☐ Cremation 3 ☐ 1 1 Donation 5 ☐ Other (Specification)	Removal from State	terans Cometa	ery 10/1=	2/05 Hu	rlock	Maryland
Dall permit. Departi Import any inj		21. Signature of Funeral Service Licer	N 2/2	22. Name and Addre	ess & Facility INERAL H	ome, P. A.		110 71/.12
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	Do not enter the mode of dying	ng, subras cardiac or	respiratory arrest,	ri do e	Approximate Interval Between
Priysician	_	Immediate Cause (Final disease or condition	a. Cola	creetal C	arunos	на		Onset and Death Smonths
/Medica Examine		resulting in death)	Due to (or as a consequence	uence of):				
P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	uence of):				
ou, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):				
0 5 0	icai		d					
OX OX h certificat ending phy use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	incv			20d Date of del	B
death death	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3 Ectopic pregnance	y 		23d. Date of del Month	Day Year
d by the letache	Phys	9 ☐ Unknown Part II. Other significant conditions of	9⊡ Unknown	ulting in the underlying cause an	ron in Part I	23e Did tobacco	use contribute to	the cause of death?
ords, F. requires that een signed b hould be deta	d by	·	orang to dod, but not room	aning at the dilacitying educe gri	on in the care is		\$. r	obably 4 Unknown
Kecords he law requires has been sign	ompleted					24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
_ ⊢ bate	O					performed? 1 ☐ Yes 2 ☐ No	death?	2 □ No
Or VICAL Physician: T this certificat ral director, pr	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	26. Place of Death ner: 4 ☐ Nursing Hom		6 ☐Other (Spe	cify)
	1 1	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo	ry at 2	8d. Describe how inju		
Attending r death. Sector: After oy the functions	Certification;	2 Accident investigatio 3 Suicide 6 Could not be determined		ome, farm, street, factory, office		8f. Location (Street a		ural Route Number,
UIVI vital or At urs after d ral Direct		4 Homicide				City or Town, Stat		
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 N. Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, death occurred at the ti tion and/or investigation, in my o	me, date and place, a opinion, death occurre	nd due to the cause(s d at the ti <i>m</i> e, date an) and manner as d place, and due	stated. to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	(0	29c. Licens	se nu <i>m</i> ber	29d. Da	ate signed (Monti	h, Day, Year)
		1 X > 1	ll Shull	D4	7232)	0/10/1	25
		30. Name and address of person who Mary S. DeShields	s, M.D., 509 Id	dlewild Avenue,	Easton, M	D 21601		
S 'Regis	tate trar	31. Date filed (Month CCT ea 1	2005 32. Revistrar's Signa	ture book				
ricgis	11111							

		-	For State	State of Ma	-		ent of H		d Ment		2005	34268
			Ragistrer 1. Decedent's Name (First, Middle, Last)			207.0770				te of Death		3. Time of Death
	Physicia	an	Thomas I. Meyer							onth Ct.	4, 200	4.4
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b.	City, Town, or	Location of De			4c. County of D	
		÷	Genesis ElderCare			161		apolis	Uro la m			e Arundel
	Funeral Director		5. Social Security Number 6. Sex 398–28–9693	7. Ag M 2□F	e (In yrs. last birth 71 Yı	Mor		Hours N	Min. 8. Da	ite of Birth lonth, Day, Y	^(ear) 1934	Birthplace (State or Foreign Country)
			Usual Residence of Decedent						nu	J. 17,	1734	NJ
	how	_	10a. State 10b. County	J - 1	10c. City, Town			lia.				10d. Inside City Limits 1 ☐ Yes 2X No
	8a-f s	Director	MD Anne A	runaeı			nnapo]	LIS		100	0141	
	with the	Dir	10e. Street and Number			10	f. Zip Code 214	101		100	g. Citizen of What	JSA
	ns 23	Funeral	857 Woodmont Road	12. Was Decedent	Ever in U.S.	13. Was E		ispanic Origin? an, Mexican, Pu	? (Specify Y	es or No-	14. Race - A	merican Indian,
36	ges 1 and 2 should be filed within 72 hours eiter death with the Maryland it of Health and Mental Hyglene. It item 27 is marked other than "neturel", or items 23e or 28e-f show or other freumatic event, the Madical Exertical must be notified at	b	1 Never Married 2 Narried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:			specify Cuba	Specify:	uerto Rican	etc.)	Specify:	/hite, etc. White
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a. C	ecedent's Give kind	Usual Occup	ation during most of d)	working	16	3b. Kind of Busine	ess/Industry
2	vithin ne. han	mpig	Elementary/Secondary (0-12)	College (1-4or	5+)			ngineer			Dofondo	Contractor
75	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	5+	IV.	ateri	ars er				aiden Sumame)	Contractor
Maryland	ld be i ental ked o ic evs	To Be	Irving Gore Mey	er				Kath	erine	Schei	ttinger	
ary	shou and M	-	19a. Informant's Name/Relationship (Ty		19b. I	Mailing Ad	dress (Street	and Number or	r Rural Rou	te Number, (City or Town, Stat	e, Zip Code)
Z	and 2 salth a n 27 ls		Anne Meyer/Wife					Road,	Anna			401
Baltimore,	of He of He It item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State		crematory	or other plac	(s) C	oct. 1	1 -	oc. Location - City	
Ë	. Pag tment tent: jury c	100	4 □ Donation 5 □ Other (Specify)		Metro				200	5	Baltimor	
Bal	permit. Pages 1 and 2 Department of Health s Importent: It item 27 li any injury or other tre 2009.		21. Six dure Funeral Service License	Dur		Bari 495	Gov. I	Sons, Ritchie	P.A. Hwy,	Sever Sever	na Park na Park,	Funeral Home MD 21146
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused ne cause on each li	the death. Do no	ot enter the	mode of dyin	ng, such as care	diac or resp	iratory arres	it,	Approximate Interval Between Onset and Death
	Physician	10	Immediate Cause (Final disease or condition resulting in death)	Cae	deac	tra	fltre	ia				
	/Medical Examiner		1000 Mily	Due to (or as	a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate		a consequence of):						
	cuted nd ransit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events	s								
,0	sician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
8760,	cate be ex physician the buria	dicai		1								
9	eath certific attending p for use as		IF FEMALE:	3c. If yes, outcome	of pregnancy						23d. Date of	delivery
Вох	death atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a	2 Fetal death		oic pregnancy or (specify)	<u>′</u>			Month	Day Year
Ŏ.	that the di ed by the detached	hys	9 Unknown	9□ Unknown					100000			
Records, P.	es ign be	by	Part II. Other significant conditions con — Faulue †	- 11 -	out not resulting in	the underly	ing cause giv	en in Part I.	2			e to the cause of death? Probably Unknown
000	> 0 70	Completed							2	4a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
- R	The ate h page	mo.							1	performe	ed? death	1? fes 2□ No
Vital	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	1				26. Place of				
	S S	²	1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpation			DOA Oth	Nursin			ce 6 Other (5	Specify)
no On	ding h. After funer	tion	27. Manner of Death Statural 5 Pending investigation	(Month, Da		ury	28c. Injur Wor	yai k? Yes 2 □ No	200. L	escribe now	injury occurred	
Division of	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of In	jury - At home, farr	n, street, fa	actory, office		28f. Le	ocation (Stre	et and Number of	Rural Route Number,
Ö	s afte	Cert	4 Homicide	building, el	tc. (Specify)					ny di Towns	State)	
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funerel Director: After the completely filled in by the funeral	edical (sician: To the best ner: On the basis of and manner st	of examination and							
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		290	d. Date signed (M	onth, Day, Year)
							D	5702	S		10-5-	05
			30. Name and address of person who co	ompleted cause of	death (Item 23a) (T	ype, Print)	0111	Aust	1310	nv	mlia	mD 211/11
	CA	ite	31. Date filed (Menth Day, Year)	. Registr	rar's Sign <u>a</u> ture	icici	ciy	TUT 2	17	1111	Julis	1110-2190
	Sta Regist		OCT 0 7 2085	Charac	S. A.	bore	رو					

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ı	Physici	an	1. Decedent's Name (First, Middle, Last) Laura Myrtle McCormick					2. Date of Deal Month 10	Day	Year 2005	3. Time of Death 11:55 P M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. Ci	y, Town, o	r Location o	of Death	10		unty of Death	
	LXdiiii	ici	HeartHomes at Lutherville	I	uthe	rvil	le		Ва	altim	ore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 166−12−4907 1□ M 2⊠ F 94 Yrs.	Month	ler 1 Year s Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) 10/11/	1911	9. Birth Mar	place (State or Foreign Intri) Yland
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of								10d. Inside City Limits 1 ☐ Yes 2X No
	Pe Ma	ecto	MD Baltimore Luthe:						0- 00	of What Cou	
	ath with the Marylan 23s or 28s-f show	Funeral Director	1414 Front Avenue		ip Code 1093			'	_	S.A.	intry :
	death	era		13. Was Dec	edent of H	ispanic Orig	gin? (Spe	city Yes or No- Rican, etc.)	14.1	Race - Amer	
920	ai', or ite	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, Give 3 Midowed 4 Divorced Year or Dates:		ecify Cuba 2∭ No	Specify:	, Puerto I	Hican, etc.)		Black, White	,etc. √hite
Maryland 21215-0036	4 within 72 hours after death with the Maryland liene. I then "natural", or Items 23s or 28s-f ehow Ite Medical Evaril, ar must be notified at	Completed	(Specify only highest grade completed) (C	lecedent's Us Give kind of v ife. DO NOT memak	vork done d use retired	ation during most	of workir	ng .		of Business/Ir	·
<u>d</u>	를 갖고 다	0	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name	(First, Middle, M	Maiden Sun	name)	
/lar		To B	Albert T. Simpson			Nan	nie	E. Ros	sier		
lan,	d 2 should th and Mer 7 is marks treumatic		1.121.1	-				Route Number	•		· ·
	deel deel am 2	1						Lutherv		on - City or T	
nor			20a. Method of Disposition 1 Magurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition Wester Method 1	iberty	other place 7 Unit	ed C		24.		-	1, MD
Baltimore,	permit. Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name	and Addres	ss of Facility	J.J.		steir	n Mort	uary, Inc.
	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lightry that initiated events C.		ode of dyin	g, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
. Box 687	at the death certificate be executed by the etending physicien and teched for use as the burlat-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3 □Ectopic 5 □ Other (f	Date of deliv Month	ery Day Year
ds, P.O.	es tha	ρ	Part II. Other significant conditions contributing to death but not resulting in the	, ,	•	en in Part I.			acco use co		he cause of death?
of Vital Records,	The law requirate has been single 2 should	Completed						24a. Was ar autopsy perform	/	b. Were auto prior to co death? 1 \(\sum \subseteq \text{Yes}	opsy findings available mpletion of cause of
/ita	ysician: The is certificete hidrector, page	Bec	25. Was case referred to medical examiner?				of Death	(Check only one			Assisted
of \	<u>ਦ</u> ≑ <u>ਰ</u>	ဥ	1 ☐ Yes ② No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim			4 1401	-	e 5 Reside			Living
	After	tion	1 Natural 5 Pending (Month, Day Year) Injui		28c. Injury Work 1 🗀 \	(? Yes 2 ☐ N		od. Dodonibo no	Williamy Coc	,uou	
	f or Attending after death. Director: After i in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, facto	ry, office		2	Bl. Location (Str. City or Town,		mber or Rura	il Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, did not not not not not not not not not not	eath occurre ir investigatio	d at the tim n, in my op	e, date and pinion, death	place, ar	nd due to the ca d at the time, da	use(s) and te and plac	manner as s e, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2	c. License	number	311			ned (Month,	
		-	M	0	V	-(((07			9/200	J
	5 Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Tyles	401	Le!	Rd	00	W301	MO	2	1204.
	Registr		COT 2 4 2005 Herry 18 Ap	artis							

Alexander Monkbe Baltimore Maryland 21215-0036

		For State Registrar	State of	Marylan		artmen rtificate				lental Hy	giene	0.05	34270
Physicia /Medic		1. Decedent's Name (First, Middle ALEXANDER	MONRO						12 4	2. Date of De Month OCTOD	Da QR/	17,2005	3. Time of Death
Examin Funeral	er	4a. Facility Name (If not institution, Makybox 5. Social Security Number	eneral /	bspi	last birthday)	4b. City, Bull If Under Months	tin	Location of	Ci	8. Date of Bir (Month, Da	rth	9. Birt	hplece (State or Foreign
Director		2 1 6 - 3 4 - 2 2 8 6 Usual Residence of Decedent 10a. State 10b. County	1 ⊠ M 2□F	6 6	Yrs.			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				938 VIR	
the Maryla 28a-f shor	Director	MARYLAND 10e. Street and Number			LTIMO		Code	-			10g Ci	itizen of What Co	1 X Yes 2 □ No
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urs after de el', or Item Examiner	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 □ Yes 2 If Yes, Give Year or Date	es? [XNo	1	was Deced If Yes, spec		n, Mexicar		ecify Yes or No Rican, etc.)	0-	Black, Whit	
ahouid be filed within 72 hours after death with the Maryland and Mental Hygiene. The Maryland marked other than "neturel", or Items 23s or 28s-f show merked other than "neturel", or Items 23s or 28s-f show metic event, Its Madical Examiner must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4	or 5+)	16a. Dece (Give life. SANIT					ing		(ind of Business/	
e d la b	Be	17. Father's Name (First, Middle, I ALEXANDER MON			DANTI	AIIO	ZV VV	18. Mothe	er's Name	(First, Middle	, Maider	LTIMORE n Sumame) MONROE	
nd 2 state at th	ř	19a. Informant's Name/Relationsh $ELIZABETH G \cdot M$	ip (Type, Print)	THER)				and Numbe	er or Rura		er, City	or Town, State, 2	Zip Code)
Pages 1 au ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (Sp.	3 □Removal from Sta	20b. F	Place of Dispo cemetery, crei . ZION	sition (Name matory or o BAPT	ne of ther place	URCH	10/2	Pate 24/05	20c. L	ocation - City or NHAM VI	
permit. Pages Department of Important: If it any injury or once.		21. Signal re of Funeral Service L	Wan	1	6	784 M	ARY	BALL	ROA.		AST	DDY ER VA.	
Enysician /Medical	V 1	23a. Part1. Enter the disease, or shock, or heart fallure. List of Immediate Cause (Final disease or condition resulting in death)	_a End	sed the deat in line.	e Re	ter the mod	e of dying	g, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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ificate be ex p physician as the buria	cai		d										
The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2⊡Feta ntattime of d	Ideath 3	⊒Ectopic pr ⊒ Other (sp						23d. Date of del Month	ivery Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditio	ns contributing to deat	th but not res	sulting in the u	nderlying c	ause give	en in Part I.			tobacco Yes 2		the cause of death?
2 2 2	Completed									24a. Was auto perfo 1 Yes		prior to death?	topsy findings available completion of cause of 2 No
ing Physician: After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo 27. Manner of Death	Hospital: 1 Drip		ER/Outpatier		A Othe	er: 4 □ Nu	ırsing Hor	n <i>(Check only o</i> me 5 ☐ Resi 28d. Describe	idence	6 □Other (Spec	cify)
To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could red	ation (Month,	Day Year)	Injury ome, farm, str	М	Work	k? Yes 2 □	No		Street ar	nd Number or Ru	iral Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical Cel	29a. Certifier t Certifyin (Check only one)	g Physicien: To the be examiner: On the basi and manne	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s	i) and manner as d place, and due	stated. to the cause(s)
To the vithin 2 To the comple	Mec	29b. Signature and title of certifier	NWACH		Ju, M		SQ.	number 540	7		29d. Da	ate signed (Monti	CS (Say, Year)
4		30. Name and address of person of Likenna N	wachuk	livu	m	· D.7	017	Tare	jan	d 670	nei	Ral 1	Lospital
Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 2	005 62. Reg	gistrar's Signa	doca	the same							-

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) OCT. 4, **Physician** JOHN **EDWARD** MC GOWAN 2005 4:00 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6061-B THOROUGHBRED COURT WALDORF CHARLES 8. Date of Birth (Month, Day, Year) Mar. 28, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Min. Months Hours **X**□M 2□ F Yrs. 84 Mar. 1921 Director 579-18-2861 Arkansas Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State nd 2 should be filed within 72 hours after death with the Marylar thin and Mental Hygiene. 27 is marked other then "natural; or items 23e or 28e-1 show trumatic event, its Medical Exacting must be notified at 1 ☐ Yes 2X No Maryland Charles Waldorf Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6061-B Thoroughbred Court 20603 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 [X] Yes 2 □ No If Yes, Give Year or Dates: 1942-14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: White Specify: 3 XWidowed 4 □ Divorced 1942-45 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Specialist US Government 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic avant 17. Father's Name (First, Middle, Last) Be Leon C. McGowan Charlotte E. Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6061-B Thoroughbred Ct., Waldorf, MD 20603 Mary Kathryn McGowan-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State **Huntt Crematory** 10-05-05 Waldorf, MD 20601 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00053 P. O. Box 156 Huntt Funeral Home Waldorf, MD 20604-0156 Thau Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Years (or as a consequence of): Due o /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause or injury Due to (or as a consequence of) Examiner certificate be executed burial-transit Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 746246 Oct. 4. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. ASHRAF MEELU, MD, 10 ST. PATRICKS DR., #408, WALDORF, MD 20603 gistrar's Signature 31. Date filed (Month, Day, Year) 32. R State OCT 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registra Certificate of Death Reg. No. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death October **Physician** 2005 Robert Dennis McNally /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1010 Auckland Way Chester Oucen Anne's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months Days Hours 1**⊠** M 2□ F 005-34-1031 67 June 6, Director 1938 Maine Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show other traumatic evant, the Maulcal Examiner rust be notified at Annapolis 1 Tayes 2 No Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21403 U.S.A. 772-C Fairview Avenue or Itams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after on and Mentat Hygiene. Is marked othar than "natural", or Ital Amed Foldes: 1XXYes 2 □ No If Yes, Give Year or Dates: 1958-67 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helena Ouinn George McNally ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traum Chester, Maryland 21619 1010 Auckland Way Laura Suplee/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Baltimore Crematory | 10/5/2005 ` 4 ☐ Donation Baltimore, Maryland Funer Service License 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non cell ung cancer Proysician Smal months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attanding Physician: 24 hours after death. Funaral Diractor: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No ပ 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗀 Homicide To the Hospital within 24 hours a To the Funaral D tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier wein 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanine Werner, MD 900 Bestack 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State 0 6 2005 Registrar

DHMH 17 Rev 1/200

ORIGINAL

			_ For	State of M	larylan						lental Hy	gien	DONE	21 070
			- State Registrar			Ce	rtifica	te of L	Death			Reg. No	5000	34273
20	Physici	an	Decedent's Name (First, Middle, La	ist)							2. Date of De Month	Da		3. Time of Death
	/Medic		Wilbur Mangum		-1		45 0:5	T	. I acation a	- (Death	Octobe		2005 County of Dea	8:58 P M
1	Examir	er	4a. Facility Name (If not institution, gir		7		1	ver1	Location of	oi Death				
_		~	Prince George's 5. Social Security Number 6.		ge (In yrs.	last birthday)	If Unde	r 1 Year	If Under		8. Date of Bir	th	rince Ge	thplace (State or Foreign
	Funeral Director			1 □ M 2 □ F	73	Yrs.	Months	Days	Hours	Min.	Jan. 3	0	1 6	ountry) cth Carolina
	P.		Usual Residence of Decedent		10- 0	ty, Town or Lo								10d. Inside City Limits
	arylar show	_	10a. State 10b. County	71	-									1 Yes 2 No
	he M	ecto	Maryland Prince (eorge's	нуа	attsvil	- 7	p Code			- I	10a Ci	itizen of What Co	
	with t	급	911 Luray Place					783					ited Sta	•
	ns 23	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.	Was Dece	dent of H	ispanic Ori	igin? (Spe	ecify Yes or No		14. Race - Ame	encan Indian,
9	or He	Ē	1 Never Married 2X Married	Armed Forces	1958		n Yes,spe 1 ☐ Yes		n, mexicar Specify:		Rican, etc.)	Ì	Black, White	
003	72 hours after death with the Maryland naturel', or items 23a or 28a-f ehow disal Exaciliar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates	: 1700									Black
15-	"nati	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give		ork done d	during mos	t of worki	ing	16b. F	Kind of Business	rindustry
12	within then	шс	Elementary/Secondary (0-12)	College (1-4or	5+)		tist		,			1	4edical	
ğ	Hyg other	BeC	17. Father's Name (First, Middle, Las	1)					18. Mothe	er's Name	(First, Middle	Maide	Sumame)	
/lar	uld by Menta Irked Itic e	To E	Wilbur Mangum						F1	ora (Crensha	w		
Maryland 21215-0036	and le mu		19a. Informant's Name/Relationship										or Town, State, .	Zip Code)
6,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if Itam 27 is marked other then "naturel", or items 23s or 28s-f ehow minipury or other traumatic event, the Medical Examination at the notified at once.		Joan Mangum 20a. Method of Disposition	(wife)	20b. F						tsville	_	0 20783 ocation - City or	
Baltimore,	ages intoth		1 Burial 2 Cremation 3		9	Place of Dispo cemetery, crea			1	10/10	1/05		•	
Ē	artme ortani injury		4 Donation 5 Other (Special Signature of Juneral Sprvice Lice		Gi	esapea 22							tsville 1 Servi	
Ba	Per Dep		1 Charles 3	Thomps	w-	/								D.C. 20012
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each	ed the deat	h. Do not en								Approximate Interval Between
198	Physician		Immediate Cause (Final disease or condition			y Fail	ure							Onset and Death 2 years
	/Medical		resulting in death)	Due to (or a	s a conseq	uence of):								
	Examiner		Sequentially list conditions,	b. Due to (or a		c Late	ral S	Scler	osis					2 years
	bed nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	juence or).								
	execunand and al-tra	Exar	that initiated events resulting in death) Last	c Due to (or a	s a conseq	juence of):								
8760,	death certificate be executed e attending physicien and of for use as the burial-transit		(d										
9	ntifical ng phy nas th	Physician/Medical	IF FEMALE:											
Вох	leath certifica attending ph i for use as th	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐Live birth	2 Feta	death 3	⊒Ectopic p						23d. Date of de	ivery Day Year
	ne des the at hed fo	/slcl	1 Yes 2 No	4□Pregnant 9□Unknown	at time of d	leath 5	Other (s	pecify)						22)
P.0	law requires that the dias been signed by the 2 should be detached		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I		23e. Did t	obacco	use contribute to	the cause of death?
Records,	uires tha signed Id be det	d by	Recurrent Sepsi	s							10	Yes 2	□No 3□Pr	obably 41 Unknown
COL	w requir	lete									24a. Was		24b. Were at	utopsy findings available
Re	و ت و	Completed									autor perfo	rmed?	death?	completion of cause of
Vital		Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
of V	Physician: this certific ral director,	2	1 Yes 2 No	Hospital: 1 ☑ Inpa	tient 2	ER/Outpatier			4 🗆 190				6 □Other (Spe	cify)
n	Jing P	i o	27. Manner of Death 1 ∑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Yea <i>r)</i>	28b. Time o Injury	f M	28c. Injun Worl	yat k? Yes 2□		28d. Describe l	how inju	ry occurred	
Division	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not	e 28a Place of I	niury - At h	ome farm st			165 2		28f. Location (Street a	nd Number or Ri	ural Route Number,
Ď	after after Direct	Certification;	4 Homicide determined		etc. (Specil		.001, 14010	,,			City or To	wn, Stat	e)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Salc		hysician: To the bes										
	To the H within 24 To the Fi complete	ledical	one)	and manner	stated.	ation and/or in				un occum				
		Σ	29b. Signature and little of certifier	MM	Af	1	10	D1.C0				290. Da	te signed (Mont	n, Day, Tear)
,	231		1-1-00					D162	13			- 1	1 -/	
			30. Name and address of person who					a c	horran	1 37	MD			
300	Sta	te	Revathy Murthy, 31. Date filed (Month Day, Year)	2005 32 legis	trar's Signa	andove	KO2	U C	never	ту,	MD			
G)	Regist		001 07	COOD COO	was s	W 19	Arthur Ballin							

wens McKamey State of Maryland / Depa 1- Registrar State Amend Item 20a-c&Unpend Item 23a	Artment of Health and Mental Hygiene Hitcate of Death The G850 takes No. 005	34274
Decedent's Name (First, Middle, Last)		3. Time of Death
William Owens McKamey, Jr		17:54 P M
4- FW- N (4 assissativation give atreat and number)	4b. City. Town, or Location of Death 4c. County of Death	

uneral Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other then "netural", or items 23a or 28a-f show eny injury or other traumatic event, ir a Madical Examinar must be notified at 2028.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

ed by the attending physicien and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be certificate

Division of Vital Records, P.O. Box 68760.

Physician/Medica Medical Certification: To Be Completed by within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

	W:	ıllıar	n owens	MCKa	mey,	JΓ	•				Uctobe	er I	1, 200	5	17:5	4 P.
	4a. Facility Name (/	f not institution	n, give street and no	umber)			4b. City,	Town, or	Location	of Death		4	c. County of [
١	1414 Sou	thview	Drive #1	08			Oxon	Hill	b			P	rince	Geor	rge!s	
	5. Social Security N		6. Sex		yrs. last bir	thday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth	9	Birthpl	ace (State	or Foreign
	579-96-	8410	XXM 2□ F		38	Yrs.	MOILLIS	Days	liouis	TVIII.	May	17,	1967	Was	ĥ.,	D.C.
ł	Usuel Residence of	Decedent														
	10a. State	10b. County		10	c. City, Tow	n or Lo	cation							10		City Limits
	Md	Prin	nceGeorg	es	0xon	H	i11								11.	s 2 No
	10e. Street and Nu	mber					10f. Zip	Code				10g. (Citizen of Wha	t Count	try?	
	1414 So	uthvi	ew Drive	<u>:</u>					2074	5			USA			
	11. Marital Status		12. Was De Armed F	cedent Ever	r in U.S.	13. \	Was Dece	dent of H	ispanic Or n. Mexica	igin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - A			
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	3 Widowed	4 Divorced	Year or				1 1 1 1 1 1 1	2126140	эрвину	·			Зреспу.			
	(Spec		it's Education st grade completed	")	16a.	(Give	ient's Usu kind of wo	rk done o	durina mos	st of work	ang	16b.	Kind of Busin	ess/Ind	lustry	
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	17. Father's Name	(Eiget Middle	(ast)			56	CULI	oy c	-		e (First, Middle				i dub () + <u>1</u>
				_												
			McKamey	, Sr				(2)			Ferg			A. 7%	Code)	
	19a. Informant's N			C	79	. маш 11	Pri	nce	Geo:	raes	al Route Num. Driv	e, cit)		10, ZIP	C00 0)	
	William		chamey,	Sr.	Ft		Wash	ingt	ton,	Mar	Driv yland	1 00-	20744 Location - Cit	T.	Chata	
	20a. Method of Dis		3 Removal from	n State	20b. Place o cemete INCOI	Y C	natory or a	ther place	e) Om	10-2	^L -05		tland	y or 10	wn, State	
	4 □ Donation				Ft. I	in	coln	Cei	il ·	10-2	1-05	B	ent#e	ed,	Md.	•
	21. Signature of Fe	uneral Service	Licensee				. Name ar	_	_							
) (a	lph	E. Wille	m	767		813 ⁿ	Poto	omac	MS F AVE	unera SE;	Twa Wa	ervic sh.,	BÇ_	2000)3
	23a. Part1. Enter t	the disease, o	r complications that t only one cause on	caused the	death. Do	not ent	er the mod	de of dyin	g, such as	s cardiac	or respiratory	arrest,			Approxim Interval B	etween
	Immediate Cause	(Final	-		ive Ca	rdi	ovacc	ular	Die	മാമ					Onset an	d Death
	disease or condition resulting in death)	OI I			onsequence		Ovabe	.u.Lu.	DIO	case						
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	Cause (Disease or	erlying r injury	<													
	that initiated event resulting in death)		c	o (or as a co	onsequence	of):										
			d													
	IF FEMALE:		23c. If yes, o	utcome of n	regnancy								23d. Date of	dolina	D/	
	23b. Was deceder in the past 12		1 Live	birth 2	Fetal death		Ectopic p		•				Month		Day	Year
	1 ☐ Yes 2 ☐ Unknown		4□Preg 9□Unk	gnant at time nown	e or ueath	2	Other (s	л а спу)								
			one contribution to	doath hut a	ot socultie = :	n tha ···	n darhia - :		on in Do-	1	23a Did	tobaco	o use contribu	to to th	A CAUSE O	f death?
	ran II. Other signi	neant conditi	ons contributing to	uoatti but fi	or resulting i	ii trie ui	nuerry and c	ause giv	en ill Fdf(236. Did	Dacc	J J30 CONTINUE		o cause o	r doann

the cause of death? Diabetes mellitus 1 🗌 Yes 2 🗆 No 3 🗌 Probebly 24b. Were autopsy findings available prior to completion of cause of death?

1 N Yes 2 □ No 24a. Was an **HIV Infection** 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1√2 Yes 2□ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1X Naturat 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

min

O.C.M.E.

October 12, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State Registrar OCT 1 7 2005

29a, Certifier

puls

_'			1 - For State Registrar	State of	f Maryland /		artmeni rtificate			nd Me		ene 2005	34275
	Physici	an	1. Decedent's Name (First, Middle	, Last)						1	2. Date of Death Month	Day Year	3. Time of Death
	/Media			JOSEPH	EDWARD	MO	RLEY				OCTOBER	15,2005	12:50 P ^M
7	Examir	er	4a. Facility Name (If not institution		nber)				Location of			4c. County of Dea	
	Funeval		1455 CLEAR VIEW 5. Social Security Number		7. Age (In yrs. last	birthday)	UIN_ If Under		BRIDGE If Under 2		B. Date of Birth	CARROLI 9. Bir	
п	Funeral Director		168-22-6544	1 ⊠ M 2□F	78	Yrs.	Months	Days	Hours	Min.	(Month, Day, Y MARCH 11		thplace (State or Foreign ountry) NSIDE, PA.
	D >		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	we or L	vestion						
	Aarylan I show	ក											10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A	Director	MARYLAND CARRO)LL	UNIC	JN B	RIDGE 10f. Zip	Code			100	g. Citizen of What Co	
	3a or	<u>-</u>	1455 CLEAR VIE	Y DOYD			21	701				U.S.A.	
	death	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S.	13.			ispanic Origi	in? (Spec	ify Yes or No- can, etc.)	14. Race - Ame Black, Whit	
36	urs after death with the Maryla al', or items 23a or 28e-f shov Examinet rount be notified at		1 Never Married 2 Married	ied 1 TYes	2 No 3/10/4	5_	1 ☐ Yes 2		Specify:	1 40110 11	Jan, 5(5)	Consider	
215-0036	72 hours after death with the Maryland netural', or items 23a or 28e-f show deat Examiner roust by notified at	ed by	3 Widowed 4 Divorced		8/8/46	Sa Dece			ation		16	Sb. Kind of Business	HITE
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212	d within giene. er than *	Completed	12	College (1		PBX	INSTAI	LLER				COMMUNICA	
	should be filed withlind Mental Hygiene. marked other than imatic event, Ita M	Be	17. Father's Name (First, Middle,	Last)					18. Mother	's Name (First, Middle, Ma	aiden Sumame)	
ya	should be and Mental marked o	P.			MORLEY						STRICK		
Maryland	0 8 a b		19a. Informant's Name/Relations									City or Town, State, .	Zip Code)
	1 an Healt em 2		RONALD D. MOR	JEY/SON	20b. Place	of Dispo	sition (Nam	ne of		Da.		MD. 21157 Oc. Location - City or	Town, State
JÖ.	0 = 0		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (S)		State	-	matory`or of		ORIUM	10/1	7/05 5	MTTHSBITE	MD.21783
Baltimore,	artm artm orta Inju		21. Signature of Euneral Service		·	7			s of Facility			ERAL HOME	110.21703
Ö	Per Per Per Per Per Per Per Per Per Per		Alan C	- Lury	·	1:	36 E.	BAL	TIMORE			IOWN, MD 2	21787
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death. Deach line.	o not en	er the mode	e of dying	g, such as ca	ardiac or	respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	HEP	A	170		FA	14	UNE		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):	-m	LM.	,		BN	00	745
Ш		e.	Sequentially list conditions, if any, leading to immediate	b. — Due to	or as a consequence	(A)	110	7)/(17/1	1810	Lyv-
V	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as a consequence	e of):							
8760	a ye	Ical		d									
9	death certifica attending ph d for use as t	Physician/Medical	IF FEMALE:								-		
Box	attend attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnancy irth 2 Fetal dea		Ectopic pre					23d. Date of de	ivery Day Year
Ö	the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno	ant at time of death own	ΣL	Other (spe	өспу)					
σ.	s that the ned by detac	by Ph	Part II. Other significant condition	ns contributing to de	eath but not resulting	j in the u	nderlying ca	ause give	en in Part I.		23e. Did toba	cco use contribute to	the cause of death?
Records,	quires an sign uld be									_	1 □ Yes	2 □ No 3 □ Pr	obably 4 Unknown
900	e law requ has been je 2 shoul	Completed									24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
ž		Com									performe	d? death?	2□No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Lie esitele				0.1		of Death (Check only one)		
of	hys this	- T	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 🗆 II	npatient 2 ER/0	Outpatier			4 LI NUIS		5 XResidend	ce 6 □Other (Spe	cify)
	ding h. After fune	tlon	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mont	th, Day Year)	Injury	M	8c. Injury Work	rat (? Yes 2 □ No		d. Describe now	injury occurred	
Division	or Attending Patter death. Director: After a in by the funera	ifica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place	of Injury - At home,	farm, st	eet, factory	, office		28		et and Number or Ru	iral Route Number,
Ö	spitel or Atten ours after deat ieral Director: filled in by the	Certification:	4 Homicide	buildir	ng, etc. (Specify)						City or Town,	State)	
	To the Hospitel or within 24 hours af To the Funeral D completely filled in	cal	(Chack only 2 Madient	g Physician: To the Examiner: On the ba	acid of ovamination	andler in	vootination	i	ملقم مام حمادمان		- A Abrilla Affrica - Indiana	and distance and dis-	A = 41 / - \
	To the Hos within 24 h To the Fur completely	Med	one) 29b Signature and title of certifier	and manr	ner stated.		_29c	. License	number		29d	Date signed (Mont	h Dav Year)
	5 1 K 1		Arta	M. Is	4		\mathcal{D}	DO 7	-03	36	~	17 מים מרויי	2005
•			29b. Signature and title of certified 30. Name and address of person 31. Date filed (Month Pay Year)	who completed caus	e of death (Item 23a	(Type.	Print)	,			2	100ER 1/	10717 0 1
_	1041		John le	Migh	,1041	IN	MIN		77.7	VM	or Isn	1000)	ハレビン
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	Registi	ar		- July	we so								

			Pleas	State of						Mental Hy			
			1 - State Registrer			Ce	rtificate	of D	eath		Reg. No.	2005	34276
T	Physici	an	1. Decedent's Name (First, Middle,							2. Date of De Month	aath Day		3. Time of Death
	/Media	cal	Ethel Mc 4a. Facility Name (If not institution.	Ilwain	her)		4h City T	own or l	Location of Dea	October		2005 County of Deatl	18:04 M
1	Examir	ier	Southern Maryl				Clin		LOCATION OF LOC			Prince G	
	- Funeral			S. Sex 7	. Age (In yrs.	last birthday)	If Under 1		If Under 24 Hr Hours Mir	. (Month, Da	rth ay, Year)	9. Birth	nplace (State or Foreign
	Director		250-30-8190 Usual Residence of Decedent	1□ M 2√ F	84	Yrs.				August	31, 1	1921 Sou	th Carolina
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	8a-fsh	ctor	Maryland Prince	Georges		Temp1e	Hills						1X Yes 2 □ No
	vith th	Director	10e. Street and Number				10f. Zip 0	ode 20748	Q		-	izen of What Co ited Sta	•
	d within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-f show the Madical Exemitmen with Demotified at	Funeral	3420 Rickey Aver	12. Was Deced	lent Ever in U	.S. 13.				Specify Yes or No		14. Race - Amer	
9	after d or Item	Fun	1 Never Married 2 Marrie	Armed Force d 1 ☐ Yes 2	es? X No		If Yes, specif		, Mexican, Puè Specify:	Specify Yes or No into Rican, etc.)	i	Black, White Specify: B1	, etc.
003	uraf,	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date									
15-	n 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of work DO NOT use	done du	ion uring most of w	orking	16b. Ki	nd of Business/I	ndustry
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nd	be filed stal Hygind other event, I	Be C	17. Father's Name (First, Middle, La							ame (First, Middle		Sumame)	
yla	should be nd Mental marked c	²	William D. McIl			400 14 8		0		. Graham			
Mai			19a. Informant's Name/Relationshi William Hall/N				_			Rural Route Numb ${\sf stown}$, 0			ip Code)
ē,	is 1 and 2 of Health a Item 27 for other train		20a. Method of Disposition			Place of Dispo	sition (Name	of		Date		cation - City or 1	Town, State
<u>m</u>	Pages nent of l ant: if it ury or o		1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		iate	-	-		ery Oct.	7,2005		ntwood,	MD.
Baltimore, Maryland 21215-0036	permit, Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Li	censee MDI	1200	22	2. Name and	Address	of Facility	Pope Fun 1315 Loc ilver Sp	eral kwoo	Homes d Drive	2000/
ē	• 46 04		23a. Part 1. Enter the disease, or co	omplications that cau	used the deat	h. Do not ent	er the mode	of dying,				, MD.	20904 Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition			NACM	PNIE	Li	INJEA	RCTION	,		Interval Between Onset and Death
) it is	/Medical		resulting in death)		r as a conseq		יופייי		110710	remore			
€.	Examiner	_	Sequentially list conditions,	b. This to for	i as a conseq	wanta alb							
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dag to (6)	as a conseq	pasitos otj.							
ó	e be executed /sicien and e burial-transit		that initiated events resulting in death) Last	c. Due to (or	r as a conseq	uence of):							
3760,	ate be hysicie ihe bu	Ical		d									
89 x	eath certificate attending phys I for use as the	/Medi	IF FEMALE:	23c. If yes, outco	ome of pream	ancy							
Вох	atten atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birt	th 2 Feta	death 3	Ectopic pred				2	23d. Date of deli- Month	Day Year
0	that the de ted by the a detached	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	vn								
S, P	200	ğ	Part II. Other significant condition END SNASE					ise given	in Part I.				the cause of death?
Ö	w require been si should I	eted	GOD SIMPE	oce will	Utst	20706				-			
Division of Vital Records,	The lav	Completed								24a. Was autor perfo		prior to co	opsy findings available ompletion of cause of
itai		0	25. Was case reterred to medical						26. Place of De	1 Yes	4	1 ☐ Yes	2L No
ž V	hysic his ce	To B	examiner? 1 Yes 2 No			ER/Outpatien	t 3 DOA	Other	4 Nursing	Home 5 ☐ Resi	dence 6	S □Other (Spec	fy)
טעס	Attending Physician: r death, sctor: After this certifice by the funeral director, p	lon:	27. Manner of Death ↑ ☑ Natural 5 ☐ Pending		Injury Day Year)	28b. Time of Injury	28d	Work?		28d. Describe	how injury	y occurred	
isic	tea for the	ertification;	2 Accident investiga 3 Suicide 6 Could no	t be 200 Blace of	f Injury - At he	ome, farm, str			es 2□No	28f. Location (Street and	d Number or Rui	al Route Number,
<u>S</u>	Ital or A	Cert	4 Homicide determin	buil di ng	, etc. (Specif	ý)	,			City or To	wn, State))	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the be	is of examina	wledge, death	occurred at vestigation, in	the time	, date and plac nion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	30h Signature and title of coeffici	and manne	a stateU.		29c. l	License i	number		29d. Date	signed (Month	Day, Year)
1			Tooking and the organical				D	403	124		OC 70	BOR 3	,2005
1	-(5)		30. Name and address of person w	no completed cause	of death (Iten	n 23a) (Type,	Print)	0.	10 (/	in IT as 4	URAL	10 mis	20735
200	Sta	te	TERRY JODRIE 31. Date filed (Month, Day, Year)	Rec	gistrar's Signa	ature	_	r-or	TU, CEI	TOTOW, P	7/110	10,000	-0121
	Registr	-	OCT 0 7 20	05 Som	e K	Appe	W						

ORIGINAL

		For State	State of	Maryland / Dep	ertificate of I			/	15 31,277
		Registrar 1. Decedent's Name (First, Middle	o, Last)		Timouto or i		2. Date of Death		3. Time of Death
Physici	- 6	DOROTHY	MAI)TE	NAYT.OR		October		ear 07:45 A M
/Medic Examin		4a. Facility Name (If not institution				Location of Deat		4c. County of	
LAUTIN	. s	210 IRISHTOWN	ROAD		NOR	TH EAST		CE	CIL
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday		If Under 24 Hrs Hours Min.		Year)	Birthplace (State or Foreign Country)
Director		219-18-5593	1 □ M 2 🗶 F	80 Yrs.			MARCH 2,		EARLEVILLE, MD
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	.ocation				10d. Inside City Limits
Maryl 1 eho	ō	MARYLAND C	ECIL		NORTH	E A CTT			1 ☐ Yes 2X No
h the Marylan r 28a-f ehow	Director	10e. Street and Number	ECTL		10f. Zip Code	ERSI	10	g. Citizen of Wh	at Country?
ath with 23a or		210 IRISHTOWN	ROAD		2	1901	UN	ITED ST	ATES OF AMERICA
deat	Funeral	11. Marital Status	12. Was Deced Armed Forc		. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race -	American Indian, White, etc.
0036 hours after death with the Maryland turel', or items 23s or 28s-1 show at Examinar results to notified at		1 Never Married 2 Marr	ied 1 □ Yes 2 If Yes, Give	™No	1 ☐ Yes 2 🛣 No			Specify:	WHITE
5-0036 72 hours at nature!', or alcal Exem	d by	3 Widowed 4 □ Divorced 15. Decedent	Year or Date		edent's Usual Occup	ation	11	6b. Kind of Busi	
215- Ithin 72 en na	olete	(Specify only highes	t grade completed)	(Giv	e kind of work done of DO NDT use retired	during most of wo	rking	ob. King or basi	nosa maasii y
	Completed	Elementary/Secondary (0-12)	College (1-4		N RESOURCE	SPECIAL	LIST RI	ETAIL DE	EPARTMENT STORE
be filed ital Hygind other	Bec	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
Should by and Menta to marked umatic ex	2	LYNNWOOD AR	CHIBALD			SADIE	KNIGHT		
re, Maryland 1 and 2 should be file 1 Health and Mental Hy item 27 is marked oth other traumatic event		19a. Informant's Name/Relations					ural Route Number,		
		GAIL L. SIMMON 20a. Method of Disposition	S / DAUGHT	ER 210 20b. Place of Disp	O IRISHTON	JN ROAD,	NORTH EAS	ST, MD 2	ty or Town, State
0 00-		1 X Burial 2 ☐ Cremation		ate DELAWARE	VETERANS	(e)			
Baltimore, permit. Pages 1 ar Depertment of Hea Important: if liem: any injury or other		4 □Donation 5 □ Other (S		MEMORIAL			14,2005	BEAR,	, DE
Depertment of the concession o		X Police	then				NERAL HOME		NF 10720
λ_{p}		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau		nter the mode of dyin	g, such as cardia	c or respiratory arres	st,	Approximate Interval Between
Priysician		Immediate Cause (Final	_						Onset and Death
/Medical		disease or condition resulting in death)	a Due to (or	rain meta	3/4 315				1 year
Examiner		Conventinity list conditions	n Co	lon Cancer	*8				4 years
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and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Dua to (o	r as a consequence of):					
1760, the be executed ysicien and ne burial-transit	cal E			as a consequence on.					
ate ate	70		d					1	
Box 61 eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				23d. Date	of delivery
Geath death death	Cla	in the past 12 months? 1 ☐ Yes 2 Ø No	4 ☐ Pregnai	nt at time of death 5	☐Ectopic pregnancy ☐ Other (specify)			Month	n Day Year
P.O at the 1 by th	Physici	9 ☐ Unknown `	9□ Unknov	m.					
15, P.O. I	by F	Part II. Other significant condition	ens contributing to dea	th but not resulting in the	underlying cause giv	en in Part I.			ute to the cause of death?
COrd	ted						1 Yes	2 /2 (No 3	☐ Probably 4 ☐Unknown
Records, The law requires t the has been signer age 2 should be of	Completed						24a. Was an autopsy performe	pric	ore autopsy findings available or to completion of cause of ath?
Vital Re licien: The l certificate ha							1 Yes 2	2No 1 E	Yes 2 No
Vision of Vital Attending Physicien: r death. ector: After this certifical by the funeral director, i) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 _ Inj	patient 2 ER/Outpatie	ont all poor Oth	05	ath Check only one Home 5 ☐ Residen		daughter's
Of Phys	<u>1:</u> ک	27. Manner of Death	28a. Date of	Injury 28b. Time	of 28c. Injur	4 🗆 Nuising i	28d. Describe how		nome
ion onding Inding atlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	9	Day Year) Injury		k? Yes 2 □ No				
Division of Vital or Attending Physicien: Teffor death. Director: After this certificat in by the funeral director, pi	Certification:	3 Suicide 6 Could determ	inad 200. Flace 0	f Injury - At home, farm, s g, etc. (Specify)	treet, factory, office		28f. Location (Stre		or Rural Route Number,
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DIVI To the Hospitel or At within 24 hours effer or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical	Examinar: On the bas	est of my knowledge, dea is of examination and/or i	ath occurred at the tir investigation, in my o	me, date and plac pinion, death occ	e, and due to the cau urred at the time, dat	use(s) and mann e and place, and	er as stated. d due to the cause(s)
the I	Med	one) 29b. Signature and title of certifie	and manne	or stated.				·	
T will		A Varl			DIE	714	()	ctober	2005
Ói		30. Name and address of person	who completed cause	of death/(Item 23a) (Trees	Print))'/		10,77	000)
10		H Farkes M	9 Sla 50	of death/(Item 23a) (Type	ern cle	superhe	Hospice.	Elkton.	Me
Sta Sta	te	31. Date filed (Month, (a) (Y) ar)	1 1 2005 ^{32. Re}	otrar's Signature	had.	1		/	
Regist	ar		y	CARLOS JO.	A STATE OF THE PARTY OF THE PAR				

			1 - For State Registrar	State of Ma	ırylar			t of H	ealth a		R	iene _{eg. N} 2 ()	05	34	278
	Physici	an	Decedent's Name (First, Middle, Last,								Date of Deat Month	Day	Year	3. Time	e of Death
	/Media	cal	EDITH STELLA NEG	street and sumbarl			45 655	T	1	(0)	October			1:1	0 a M
	Examir	ier	11750 Asbury Circ			ury' s N.H.			Location o	or Death		Calv	nty of Death	1	
	Funeral		Social Security Number 6. S	7. Age		last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birth (Month, Day,		9. Birth	place (Sta	te or Foreign
	Director		Usual Residence of Decedent]M 2∭F	97	Yrs.	Months	Days	Hours	Min.	Sept. 28	, 1908	Cou	intry) y Land	_
	d within 72 hours after death with the Maryland piene. Ir then "naturel", or Items 23e or 28e-1 show Itte Madical Exactiter nast be notified at	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation								City Limits
	he M	Funeral Director	Maryland Prince G	eorge's	Нуа	ttsvil									es 2 □ No
	with 8	급			0		10f. Zip				1	0g. Citiz <i>e</i> n o		intry?	
	death	era	5805 42nd Avenue	12. Was Decedent E		.S. 13. V		781 lent of His	spanic Orio	zin? (Spe	cify Yes or No-	U.S.A	A . ace - Ameri	ican Indian	
9	or ite	FUT	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 N	0					, Puerto F	cify Yes or No- Rican, etc.)	В	lack, White	, etc.	,
003	urel',	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Yes 2					Spec	eify: Wh	ite	
21215-0036	"natu	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced (Give	kind of wor	k done d	urina most	of workin	ng	16b. Kind of	Business/Ir	ndustry	
12	within lene. then "	dmc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		00 NOT us k – Т					77		٠,	
p	e filed at Hygie other i	Be C	17. Father's Name (First, Middle, Last)			OTEL	K - 1	ypis		r's Name	(First, Middle, A			OI	Maryland
ılar	uld be Aenta rrked tic ev	To B	William Reeves						Eliza	heth	Earnsh	aw			
Maryland	s 1 and 2 should be filed of Health and Mental Hygitem 27 is marked other other treumatic event,	ľ	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address				Route Number,		n, State, Zij	p Code)	
	is 1 and 2 of Health a item 27 is other tree		James W. Hetzler -	Nephew		280	Owing	s Hi	11 Co	urt,	Owings	, Mary	land	20736	5
lore	Pages 1 nent of H ont: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	emoval from State	20b. P	Place of Dispos emetery, cren	sition (Narr natory or ot	ne of ther place)	Da	ate	20c. Location	n - City or T	own, State	
altimore,	# E E E		' 4 □ Donation 5 □ Other (Specify)		Met:	ropolita	n Cre	mato	ry 0	ct. 7	, 2005_	Alexar	ndria	Vir	ginia
Ba	permi Depa Impo eny ir		21. Signature of Funeral Service Ligens	1.3.2	4						ch's Fu				
			23a. Part1. Enter the disease, or compli	cations that caused	the deatl						, Hyatt		, MD	Approxim	
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	/Medical		disease or condition resulting in death)	. Hyperter Due to (or as a											
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687	death certificate be executed e attending physician and id for use as the burial-transit	edical													-
Box	eath certific attending p for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of								23d. D	ate of delive	erv	
		icia	in the past 12 months? 1 ☐ Yes 2 🎛 No	1 Live birth 2			Ectopic pre Other (spe						lonth	Day	Year
P.0.	that the de ed by the detached	Physician/M	9 🗆 Unknown	9Li Unknown											
Vital Records, I	The law requires that the steep seem signed by the page 2 should be detache	by	Part II. Other significant conditions cor	tributing to death bu	t not resu	ulting in the un	derlying ca	iuse giver	n in Part I.		23e. Did tob	acco use cor s 2∑No			
eco	e faw re has be	Completed									24a. Was an		. Were auto	psy finding	s available
œ —		Com									autopsy perform	ed? No	prior to co death? 1 \(\subseteq \text{Yes}	2∐ No	cause of
/ita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?								Check only one)			
of	Phys this al dii	To	1 ☐ Yes 2 X No 27. Manner of Death			ER/Outpatient		A Other	4X Nurs		e 5 🗌 Resid <i>e</i> r			y)	
no	ding Afte fune	tlon	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	M 28	Bc. Injury : Work?	at } es 2∐N		3d. Describe how	v injury occu	rred		
Division	or Attending after death. Director: After in by the funer	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	v - At ho	me, farm, stre			03 2 11		3f. Location (Stre	eet and Num	ber or Rum	l Route No	ımher
<u>S</u>	s after s after of Dire	Certification;	4 Homicide	building, etc.	(Specify	")					City or Town,	State)	001 01 1 1010		moer,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of ler: On the basis of and manner state	examınat	wledge, death tion and/or inve	occurred a estigation,	it the time in my opi	, date and nion, death	place, an	nd due to the car of at the time, da	use(s) and m te and place,	anner as si , and due to	tated.	o(s)
	To the within 2. To the L	ž	29b. Signature and title of certifier				29c.	License			1	d. Date signe	-		
			1 4. Ja				_	70	051	164	2	Octobe	er 5,	2005	
2	(10)		30. Name an address of person who co John Joseph Barth,					land	Road	l S	Soloma	ns Ma	rvlor	od 204	588
	Sta	te	31. Date filed (Month, Day, Year)	₽2. Registrar	's Signat	ture				,	DOTOMA	, IId	. <u>. у та</u> 1.	<u>.u 200</u>	
	Registr	ar 🕆	OCT 0 7 2005	Stone	J.	Sport									

			For State Registrar	State of Mary	-	artment of H tificate of L			ene 2005	34279
	Physici	an	1. Decedent's Name (First, Middle, La	st)				Date of Death Month	Day Year	3. Time of Death
	/Medic		Owen Charl	es Parish				October	6 2005	8:24p. M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
			Memorial Hospit				erland		Alleg	any
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		235-51-2073 Usual Residence of Decedent		Yrs.	10 7		Nov. 29,	2004 Cun	berland, MD
	land W		10a. State 10b. County	10	c. City, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Many f sh	ro	WV Miner	-1	77					1 ☐ Yes 2 🙀 No
	28a	rec	10e. Street and Number	aı	Keyser	10f. Zip Code		100	g. Citizen of What C	ountry?
	3a or	Funeral Director	Susan Fleek Ro	ad		26726			USA	,
	ms 2	nera	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba		cify Yes or No-	14. Race - Am	
9	after or Ite	Ī	1 XNever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No				Rican, etc.)	Black, Whi	
03	72 hours after death with the Maryland natural; or Items 23a or 28a-f show disal Ezaminar must be rediffed at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 □ Yes 2 😿 No	Specify:		Specify: W	nite
21215-0036	72 h 'natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of work	ing 16	6b. Kind of Business	/Industry
12	han '	ф	Elementary/Secondary (0-12)	College (1-4or 5+)	life.					
2	2 should be filed within and Mental Hygiene. is marked othar than " aumatic avant, the Me		17. Father's Name (First, Middle, Last)		Never W		(First, Middle, Ma	N/A	
anc	ntal Hed of	Be								
Ž	hould d Men marke maric	2	William A. Par 19a. Informant's Name/Relationship (10h Mailie	- Address (Ctroot		Damaris		77. 0. 4.1
Maryland			Mr. & Mrs. Willia	**					City or Town, State,	ZIP Code)
	1 and Health am 27 ther to		20a. Method of Disposition		Ob. Place of Dispo				6726 Oc. Location - City or	Town State
ō	Pages nent of int: If it.		1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer	natory or other place	Oct.	11		
Baltimore,			*4 □ Donation 5 □ Other (Specifical Service Lice)			y Cemeter . Name and Addres			Reese's M	i11, WV
Ba	permit. Departr Importa any inju		Buch	Shill			ЭH	ith Fune		
			23a. Part1. Enter the disease, or com	plications that caused the	death. Do not ent				, WV 267	Approximate Interval Between
	Physician /Medical Examiner	ner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Finer Underlying		shock	ry Arrest				Onset and Death 2 hours
68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a co	nsequence of):					
O. Box	by th	Completed by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Э,	wrequires that the sbeen signed by the should be detache	y P	Part II. Other significant conditions	contributing to death but ne	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rās	quire on sig uld b	pe t	Hypoxic enceph	alopathy, se	vere			1 ☐ Yes	2 ▼ No 3□P	robably 4 Unknown
of Vital Records,	e law has b	omplet	seizure disord	er				24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
tal	ician: Th certificate rector, pag	a l	25. Was case referred to medical			-	26 Place of Death	1 Yes 2	No 1 Yes	2 □ No
>	9 0 T	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	2 ER/Outpatier	at 3 DOA Othe	×-		ce 6 □Other (Spe	ecifu)
0	ding Phys h. After this funeral di	n.	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time o			28d. Describe how		,
0	Attanding r death. actor: After by the fune	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		un) injury		Yes 2□No			
Division	al or Atta s after de al Diracto ad in by th	Certification:	3 Suicide 6 Could not be determined		At home, farm, str pecify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	29a. Certifier (Check only one)	nysician: To the best of m miner: On the basis of exa and manner stated	y knowledge, deat mination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	10-	4,0	29c. License	a number	290	d. Date signed (Mon	1
			I (huter V	J Dem	MI	D	62616		10/07	12005
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,					
-			Ruben W. Cerr		7 Nationa	al Highway	y LaVal	e, MD 2	1502	
	Sta	ate	31. Date filed (Month, Day, Year)	32 degistrar's	Signature	- A -				

		•	1 - For State Registrar	State of M	laryland / Dep Ce	ertificate of			giene Reg. No.	05	34280
	Physici	an	1. Decedent's Name (First, Middle, La Madeline Rose Po					2. Date of Dea Month October	Day	2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv)	4b. City, Town, o		eath	4c. Coun	ty of Death	
	Funeral Director		218-30-9130	Sex 7. A	ge (In yrs. last birthday 91 Yrs.	Months Days		frs. 8. Date of Birt lin. (Month, Da Oct 21	1913	9. Birthpl Count Bruns	lace (State or Foreign try) Swick, MD
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Freder:	ick	10c. City, Town or L		,			10	0d. Inside City Limits
	n with the 3a or 28a st be notifi	Funeral Director	10e. Street and Number 3509 Cemetery Ci:	rcle		10f. Zip Code 217	758		10g. Citizen of US.		try?
980	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, tra Medical Examinet must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	INo	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		(Specify Yes or No- erto Rican, etc.)	- 14. Ra BI Spec	ace - America lack, White, e efy: Wh	
21215-0036	d within 72 ho giene. or than "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade co <i>mpleted)</i> College (1-4or	(Giv life.	edent's Usual Occu e kind of work done DO NOT use retire nemaker	during most of	working	16b. Kind of	Business/Ind	ustry
land	ld be file ental Hy ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last Leonard Harper)				Name (First, Middle, a V. Myers		ame)	
Maryland	d 2 shou th and M 7 Is mar traumati	-	19a. Informant's Name/Relationship (William F. Huffm	, ,				Rural Route Numbe			Code) MD 70853
altimore,	Pages 1 an ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Domation 5 □ Other (Special	(y) 110	,	position (Name of permatory or other pla l Cemetery		Date 10/2005	20c. Location		
Balt	permit. Departi Import any inj		21. Sign di jayservice di sarbara A. Wi	lliams, Ov	vner j		illiams sville H	Funeral H Road, Brun		MD 21	.716
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each			_	fiac or respiratory ar		e/-	Approximate Interval Between Onset and Death
	/Medical Examiner	er	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):		AILURE		,, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>		
8760,	death certificate be executed e attending physician and d for use as the burial-transit	icai Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c. Conon Due to (or a	s a consequence of):	Teny D	1 SEAS C				
O. Box 68	ne death certifi the attending thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у			ate of deliver	ry Day Year
rds, P.	ires sign d be	by	Part II. Other significant conditions of	contributing to death	but not resulting in the	underlying cause gr	ven in Part I.		obacco use co es 2 No		e cause of death?
Vital Records,	The law ate has b page 2 st	Completed						24a. Was autop perfor 1 🗆 Yes		Were autop prior to con death? 1 \(\text{Yes} \)	osy findings available inpletion of cause of 2 No
of Vita	Physiclan: This certificated director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 Inpat	ient 2 ☐ ER/Outpatio	ent 3 DOA	200	Death <i>(Check only o</i> g Home 5 ☐ Resid		ther (Specify)
ion o	ding After fune	ertification:	27. Manner of Death 1 🛱 Natural 5 □ Pending 2 □ Accident investigatio		ury ay Year) 28b. Time Injury	Wo	ryat rk?]Yes 2 □ No	28d. Describe h	now injury occu	urred	
Division	in the	Certific	3 Suicide 6 Could not be determined	286. Place of it	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 ☐ Certifying PI (Check only one)	nysician: To the bes miner: On the basis and manner s	t of my knowledge, dea of examination and/or i tated.	ath occurred at the ti nvestigation, in my	me, date and pla opinion, death o	ace, and due to the occurred at the time,	cause(s) and m date and place	nanner as sta , and due to	ated. the cause(s)
)	To the To the comp	Me	29b. Signature and title of certifier	Author	8	29c. Licen	se number 0 5 11 5		29d. Date sign		
	5		30. Name and address of person who	4 9701	4.6		ROCK		102	0850	
	Sta Registr	67	31. Date filed (MoUCT, Year) 2		trar's Signature						

			1 - For State Registrar	State of Maryla		artment of I			giene 005	34281
	Dhusisi		Decedent's Name (First, Middle, Last)				· · · · · · · · · · · · · · · · · · ·	2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medio		George Bur		.1			Octob	er 6,2005	
	Examin	er	4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, o			4c. County of Dea	
			405 East Cecil 5. Social Security Number 6. Sex		rs. last birthday)	North	1 East	Hrs 9 Date of Birt	Ceci	
	Funeral Director			4 ^{2□} F 87	Yrs.	Months Days		Min. (Month, Da)	Y Year) 9. Bill	thplace (State or Foreign buntry) MD
			Usual Residence of Decedent	- 07				APLII	Ceci , Year) 9. Bin 12,1918	
	how		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	cto	MD Cecil		Nort	h East				1 ☐ Yes 2√2 No
	dith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	
	s 23e	ral	405 East Ceci		- 11.0	219		-0/0 " "	U.S.A.	
	ltem Item	Funeral Director	11. Marital Status 1☐ Never Married 2☐ Married 12	2. Was Decedent Ever in Armed Forces?	10.5.	if Yes, specify Cub	an, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
336	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give V Year or Dates:	WII	1 □ Yes 2√2 No	Specify:		Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene. ed other then "natural", or Items 23a or 28a-f show event, the Medical Esaminar must be notified at	Completed	15. Decedent's Educa		16a. Deced	dent's Usual Occup	oation	d working	16b. Kind of Business/	Industry
21	within 7 ene. then "r	nple.	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire		1	_	
	filed wi Hygien Sther th	S	11	3	Mas	ter Ele			Construc	tion
and	be fi	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		
ž	should be and Mental s marked o	ပို	Zebley F. 19a. Informant's Name/Relationship (Type		10h Mailir	a Address (Street		B. Came	r, City or Town, State, 2	Zin Code)
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic					30x 22,			1922	.ip 00de)
_	s 1 ar f Hea item other		Robert Powell/S 20a. Method of Disposition		. Place of Dispo	sition (Name of	35.5	Date	20c. Location - City or	Town, State
Ę	8°= 5		1 Burial 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	North E	matory or other pla Cast Met	hodis	t Octobe	r, Nort	h East, MD
Baltimore,	in program		21. Signature of Furieral Service Licensee	Co	emeter ₂	. Name and Addre	ss of Facility	10,2005		
ã	Dep any any		Stelle				_	e Funera		01001
Ħ			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	itions that caused the dicause on each line.	eeth. Do not ent	erthe mode tr ayir	ng, soch as ca	rola of respiratory a	Eon, MD	o te Interval Between
1	Physician		Immediate Cause (Final disease or condition	Acute	Myou	ardral	INF	arction		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):		A 1			1
1	_xammor	<u></u>	Sequentially list conditions, b.	Due to (or as a cons		navy	Hote	ry Dise	ese	4-12
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00 0 00 10	, oqua, 100 or j.	/		t.		
<u>,</u>	execun n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	ate be executed hysician and the burial-transit		L d.				<u> </u>			
9	ntifica ng ph as th	Ned	IF FEMALE:							
Вох	ath certif attending for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	t. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etel death 3	Ectopic pregnancy	y		23d. Date of deli	ivery Day Year
	the at	sici	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	of death 5] Other (specify) _			Wichar	Day
P.0	that the de led by the a detached t		Part II. Other significant conditions contr	ibuting to death but not	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	uires tha signed Id be del	d by	•	, and the second	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, 1□Y	es 2x No 3□Pro	obably 4 DUnknown
9	w require been sig should t	Completed						24a. Was a	an 24b Were au	topsy findings available
Re	he tav e has age 2	dwo						— autop: perfor	sy prior to death?	completion of cause of 2 No
ta	sicien: The certificate ha	40	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only or		20110
(nysici iis ce direc	To B	examiner? 1 Yes 2 40	spital: 1 🗌 Inpatient 2	ER/Outpatien	t 3 DOA Oth	өг: 4 🗆 Nursi	ng Home 5 X Resid	ence 6 □Other (Spec	cify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Wor			ow injury occurred	
sio	uttendi death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division	or At after of Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		City or Tow	treet and Number or Ru n, State)	rai Houte Number,
	spitel ours a		29a. Certifier Certifying Physic	ian: To the best of my l	knowledge, death	occurred at the tir	ne, date and r	place, and due to the c	ause(s) and manner as	stated.
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		r: On the basis of exam and manner stated.						
	To the vithing To the comp	X	29b. Signature and title of certifier	1110		29c. Licens	1	= , 1	9d. Date signed (Month	
			1 ille UEn	CH PO		DO	0311	27	10-06-	05
11	+ (VA		30. Name d address of person who com	pleted ca e of death (I				11. 1 01	-0.1	11 K - 1 N - 1
10	Control of the last		Christopher Wen 31. Date filed (Morth, Day, Year)	del MD;	Suite Z	02, 111	VV, A	tigh St;	ElKton,	MD 21921
	Sta Registr		QCT 0.7 2005	32. Registrar's Sig	Look			-		
	A CALL			The same of the sa	1				22.5.5	

DHMH 17 Rev 1/200

OCT 0 7 2005

		1 - For State Registrar		(Certificate of	Death	1	Reg. No.	2005	31,283
Physici	ian	1. Decedent's Name (First, Middle, La	ast)				2. Date of De	ath Day	Year	3. Time of Death
/Media		Rose Mary	Rockinber	g			October			3:20 P M
Examir	ner	4a. Facility Name (If not institution, gi				or Location of Dea	ith		County of Death	
Francis		Carroll Hospita 5. Social Security Number 6.		(In yrs. last birth		minster If Under 24 Hr	s. 8. Date of Birt		Carroll	place (State or Foreign
Funeral Director		,	1 N 2 N E		s. Months Days	Hours Mir		v. Year)	31 New	ntrv)
_		Usual Residence of Decedent		40.00						
shov	5	10a. State 10b. County		10c. City, Town						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the Marylan	Director	Maryland Carrol 10e. Street and Number	L.L	Mt. Ai	ry 10f, Zip Code			10a Citi	zen of What Cou	
= 5 ₪		805 Butternut Ci	rolo		21771					
atter death wi or Itama 23a miner must b	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	Hispanic Origin? (Specify Yes or No		ted Stat 14. Race - Ameri	can Indian,
after or Ita		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0	1 ☐ Yes 2 ☑ No		rto Hican, etc.))	Black, White,	etc. nite
72 hours 'natural', dical Eva	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:							
in 72 i "nat	ojete	15. Decedent's E (Specify only highest gi	rade completed)	(Decedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of w	orking	16b. Ki	nd of Business/In	dustry
jene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	+)	Homemaker	-/			Own Hom	ie
d 2 should be filed within 72 hours th and Menal Hygiene. 77 is marked othar than "natural; traumatic evant, I'm Medical Ex	Be C	17. Father's Name (First, Middle, Las	st)			18. Mother's Na	ame (First, Middle,	Maiden		
should b nd Ments markad umatic e	To	Joseph Gebbia				Anit	a Bonollo)		
2 sho		19a. Informant's Name/Relationship			Mailing Address (Street					
1 and Health		Patrick T. Rockin 20a. Method of Disposition	nberg / Son	-	Butternut Disposition (Name of	Circle	Mt. Air			
ages nt of h :: if its		1 ☐ Burial 2 ☑ Cremation 3		cemetery	crematory or other pla	ce) Oct	ober 12,	20c. Lo	cation - City or To	own, State
2 2 5 5		* 4 □Dopation 5 □ Other (Speci		77 1	1 6	OCL				
artm orta		21. Sanature of the Service Lice		Freder	ck Cremato	ry	2005	Fred	erick, M	Maryland
permit. Departm Importa any inju		21. Synature of the Service Lice		Freder	22. Name and Addre	ry sess of Facility S	2005 tauffer H	unei	al Home	s, P.A.
permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trac		23a, Part1, Enter the disease, or cor	ensee	the death. Do no	22. Name and Addre	ry ess of Facility S ville Bl	2005 tauffer I vd. Mt.	une: Air	al Home	s, P.A. and 21771
Departm Departm Imports any inju		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	ensee	the death. Do no	22. Name and Address 8 E. ridge t enter the mode of dyin	ry ess of Facility S ville Bl ng, such as cardin	2005 tauffer I vd. Mt.	uneı Air	al Home	s, P.A. and 21771
Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused to y one cause on each line	the death. Do no	22. Name and Address 8 E. ridge t enter the mode of dyin	ry ess of Facility S ville Bl ng, such as cardin	2005 tauffer I vd. Mt.	uneı Air	al Home	s, P.A. and 21771 Approximate Interval Between
Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused line y one cause on each line a. Due to (or as a	the death. Do not all the death. Do not all	22. Name and Address 8 E. ridge t enter the mode of dyin	ry ess of Facility S ville Bl ng, such as cardin	2005 tauffer I vd. Mt.	uneı Air	al Home	s, P.A. and 21771 Approximate Interval Between
Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, iscoming to immediate cause. Enter Underlying Cause (Disease or injury)	mplications that caused line y one cause on each line a. Due to (or as a	the death. Do no	22. Name and Address 8 E. ridge t enter the mode of dyin	ry ess of Facility S ville Bl ng, such as cardin	2005 tauffer I vd. Mt.	uneı Air	al Home	s, P.A. and 21771 Approximate Interval Between
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State Registrar

Division of Vital Records, P.O. Box 68760,

30: Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. KUMGH I) KUNGH 349 N

31. Date filed (Month, Day, Year)

33 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene-34284 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 7 Day Physician Helen Valeria 2005 Rice 12:40 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10606 Powell Road Thurmont Frederick 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 10, 1919 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 214-10-1171 86 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Maryland Frederick Thurmont Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10606 Powell Road 21788 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacture Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be finance in and Mental P John Russell Huff Eleaner Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a 6022 Mountaindale Rd, Thurmont, MD 21788 Susan O'Toole/Nieces Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 Burial 2 □ Cremation 3 □ Removal from State pernit, Page Department o Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel Cemetery 10/11/2005 Libertytown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fulfare. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jur as Examiner g physicien and as the burial-transit The law requires that the death certificate be executed Due to (or !! Box 68760, Physician/Medical use as t attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year signed by the at d be detached for 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 🗌 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificete has t irector, page 2 s 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No of Vital within 24 hours atter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 XYes 2 □ No Certification: To Be 26. Place of Death | Check only one Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation njury 24 05 1 🗌 Yes 2 No Tall 2 Accident 6 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Resider(E 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 10606 To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26516 OCTOBER 9 2005 pleted cause of death (Item 23a) (Type, Print) 1475 TANEY AUE. FREDERICK MD 21702 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2005

			For State Registrar	State of Maryla		rtificate of		Reg. N		34285
40	Physici	1	1. Decedent's Name (First, Middle, Last)				:	2. Date of Death Month D	ay Year	3. Time of Death
	/Medic		ROBERT		ODERICK				7, 2005	7:32 P M
) .	Examin	er	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death	4	c. County of Death	
			Frederick Memoria		1 11:11 1	Frederi			Frederic	
8.	Funeral Director		5. Social Security Number 6. Sex 115	M 2□F 7. Age (In y	rs. last birthday) 7 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Year	9. Birthp Coun	ace (State or Foreign try)
dár.			Usual Residence of Decedent	- /				OCT. 17, 19	932 Mar	yland
	yland		10a. State 10b. County		City, Town or Lo				1	Od. Inside City Limits
	a-1-a	ctor	Maryland Frederi	ck	Rocky	Ridge				1 ☐ Yes 2 No
	or 28	Olre	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Coun	try?
	ath w	Funeral Director	9309 Rocky Ridge			2177			nited Sta	tes
	er de	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Spec an, Mexican, Puerto R	rfy Yes or No- ican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: Ko		1 ☐ Yes 2 🎇 No	Specify:		Specify: Whi	te
215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f show La Medical Exacting must be collified at	ted !	15. Decedent's Edu	cation		dent's Usual Occup	pation	16b	Kind of Business/Inc	lustry
215	nin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	pation during most of working d)	9		
21	giene.	Com	11	College (1-401 54)	Pair	nting Con	tractor	Но	use Paint	ing
nd	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or liams 23a or 28a-f ahow avant, it a Medical Exacting must be indiffed at	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, Maide	n Surname)	
yla	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, Ite Ma	ပ္	Norman F.	Rhoderic			Eva	Dra	<u> </u>	
Maryland	12 sh n and 7 Is m maum	7	19a. Informant's Name/Relationship (Ty)		1		and Number or Rural			
	s 1 and 2 should if Heelth and Mer item 27 Is marke other traumatic		Michael Rhoderick 20a. Method of Disposition		9808 o. Place of Dispo		Store Lan		stown, MD	
Baltimore,	9 = 5		1 ☐ Burial 2 ☑ Cremation 3 ☐ R	lemoval from State	cemetery, crer	natory`or other plac	ce)		·	
Ħ			4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		rederick	Cremato Name and Addre	ry 10/13,	/2005 Fre	ederick, N	Maryland
Ba	Departm Departm Imports any inju		Raymond	Pelerson	1	04 E. Ma	in St. / T	uffer Fun hurmont, 1	eral Home Maryland :	s, P. A. 21788
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	/Medical Examiner		resulting in death)	to (or as a cons	sequence of):					-0
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99	rtificate ng phys		IE FEMALE.							
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O. E.	at the dea by the al tached to	Physician/N	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Year
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Records,	ires tha signed I d be det	d by	Tarrit. Still Significant Conditions Con	and the death out not	easnimid in the n	idenying cause giv	en in Faiti.		11	ably 4 Unknown
Ö	w require been si should t	Completed							^	
Rec	has has ge 2 :	mp						24a. Was an autopsy	prior to con	sy findings available apletion of cause of
			05.19/2		1000			performed? 1□ Yes 202N	o 1 Yes	2 No
Vital	Physician: this certific ral director,) Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	Vene	t 3DDOA Oth	26. Place of Death			
ō	€ = E	: To	27. Manger of Teath	1 ☐ Inpatient 2 28a. Date of Injury	28b. Time of	JU DON	4 🗆 Muising Homi	e 5 Residence)
lon	nding I tth. :: After e funer	0	Natural 5 Pending investigation	(Month, Day Year) Injury	28c. Injur Wor	k? Yes 2□No	,,,	.,	
Division		#	2 Accident							
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	ital or Atter rs efter dea el Director ed in by the	Certification:	3 Suicide 6 □ Could not be	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office	28	If. Location (Street a City or Town, Star	ind Number or Rural te)	Route Number,
۵	Aspital or Atter 4 hours efter dea 5 unerel Director ely filled in by the		3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Spe	ecify)	occurred at the tir	ne, date and place, an	City or Town, Star	s) and manner as st	aled
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State of Maryland / Department of Health and Mental Hygiene 005 34286 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year William Arthur Riley, Jr. October 6, 2005 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Nursing Home Mount Airy Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□F Months Days Director 218-36-9368 64 March 24, 1941 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location r 28a-f show show 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland | Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With r than "natural", or itema 23a or the Medical Examiner must be 14217 Black Ankle Road 21771 Funerai United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2XX No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ jes 1 and 2 should be filed v of Health and Mental Hygie If itam 27 Is markad other t or other traumatic event, the other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Arthur Riley, Sr. Laura Virginia Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Riley / Wife 14217 Black Ankle Rd. Mt. Airy, MD 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 10, 20c. Location - City or Town, State Pages ö ortant: If i 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. ⁴ 4 □ Donation Other (Specify) Resthaven Mem. Gardens 2005 Frederick, Maryland 21. Signature Fund Service Lice 1998 Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enforthe disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician IVER CIRRHUSIS /Medical Due to (or as a consequence of): **Examiner** MICHOLOC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-translt Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the 0 9□ Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Vital 2 🗆 No 1 Tyes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one Hospital: Other: 2 1 Yes 2 No 4 P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ n 24 hours after ne Funeral Dire bletely filled in b 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Certifying Physician: 10 the best of my knowledge, usean occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I To the 29d. Date signed (Month, Day, Year) mo 035965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14ARDING 602 CENTER ST. #209 MT. ALRY, MD 2177/ MD. aegistrar's Signature State Registrar

	-	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 0 0 5 34287								87		
Physicia		1. Decedent's Name (First, Middle, Last) Leo F. Robinette					Mo	te of Death	Day Ye	3. Time of	Death	
/Medica										18TH , 2 4c. County of I	2005 11:0 Death)0
Funeral		MEMORIAL HOSPIT 5. Social Security Number	2.2	7. Age (In yrs.	last birthday)	CUMBER If Under 1 Yea	r If Under	24 Hrs. 8. Da	te of Birth	ALLEGAN	Birthplace (State or	r Foreign
Director		165-22-1848 Usual Residence of Decedent	1 M 2 F	80	Yrs.	Months Days	s Hours	Apr	30, 19	25	PA)	
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with the Maryland e or 28e-f show		MD Alleg 10e. Street and Number	ally		Cumb	10f. Zip Code			10g.	Citizen of Wha		20140
ath wit	ra D	12909 Brice Hollow Road, SE				21502				USA		
ē <u>\$</u>	by Funeral	11. Marital Status 1 □ Never Married ★□ Married 3 □ Widowed 4 □ Divorced	Amed F	2 □ No iveX		Was Decedent of f Yes, specify Cu 1 ☐ Yes Ž☐ No		gin? (Specify Ye i, Puerto Rican,	es or No- etc.)		American Indian, White, etc. 'hite	
15-0	Completed	(Specify only highe	t's Education st grade completed,		16a. Deced (Give life.	dent's Usual Occi kind of work done DO NOT use retir	upation e during mos ed)	t of working	16b	. Kind of Busin	ess/Industry	
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laryland 212' 2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Owen Robine	•				Esth	er's Name <i>(First,</i> ner John	nson Ro	binette		
Maryla		19a. Informant's Name/Relations Myrtle Robinette	hip (Type, Print)	fe	19b. Mailir 1290	g Address (Stree 9 Brice h	and Number	Rd C	e Number, Cit umberl	y or Town, Sta and	MD 21502	<u>, </u>
Baltimore, M semit. Pages 1 and 2 Department of Health mportant: If item 27 1 any Injury or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from	State	Lace of Dispo emetery, crer Labor Ce	sition (Name of natory or other pl	ace)	Date 10/21		Location - City	y or Town, State	
Baltimo permit. Pag Department Important: It any Injury o		21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	1 1 1		. Name and Addi Scarpe	ess of Facilit III Funer			J	11	
m 40 = # 9		23a. Han, Enter the disease, or	complications that	caused the death		108 Vir	ginia Av	enue: Cur	mberiand	i, MD 21		,
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Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Fetal Inant at time of de nown	death 3	Ectopic pregnan Other (specify)	су			23d. Date of Month	,	ear
Cords, P	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to HYPOTHYROIDISM, ATRIAL FIBRILLATION 1 Yes 2 No 3 Pro										
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Division Jor Attending after death. Diractor: After	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 256. Plac	8e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Loc Cit	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Hospi 14 hou Funer Fely fill	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
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		30 Name and address of person	who completed cau	Ise of death (Item	23a) TVD)54411			CTOBER	18TH, 20	05
4		CATIZING DEVE	T W M	.D., 500	MEMOR		NUE, SI	UITE 105	, CUME	BERLAND	, MD 2150	2
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	Physici		Ernest Franklin	Riley				OCT. 3.	Day Year	1451 P M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER 4b. City, Town, or Location CHEVERLY				ation of Death				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					B. Date of Birth (Month, Day, Young)	9. Bir	thplace (State or Foreign punity) hington DC	
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. do other then "neturel", or items 23e or 28e-1 show event, the Medical Examiner must be multiled at	D D		Usual Residence of Decedent								
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	28a-	Directo	Maryland Charles Wa 10e. Street and Number			10f. Zip Code		. Citizen of What Co	ountry?		
	th with	a D	4206 Sandwich Ci	2060)1	USA					
	leted by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Agmed Forces?			B. Was Decedent of Hispar If Yes, specify Cuban, M	ify Yes or No-		14. Race - American Indian, Black, White, etc.			
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			20a. Method of Disposition 20b. Place of Disposition (Name of commerciary, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State								
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<u>m</u>	B B B B		Mert & Sado	uno		Huntt Funera	al Home	Waldor	f, MD 206	504-0156	
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Vis	i or Attendater deati Director:	tifica	3 Suicide 6 Could not b 4 Homicide determined	208. Flace of Hij	idding, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State) R+5+Post Office Rd		
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier 29c. License number OCMF.						Date signed (Month, Dey, Year)		
			Lard Hallowma						OCT. 4, 2005		
1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201								and 21201		
	Sta Regist		31. Date filed (Month, Day, Year) OCT 0 6	2005 32. Refistr	ar's Signature	Sperte					
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¥	Physici	an	1. Decedent's Name (First, Middle								2. Date of De Month	eath Day	Year	3. Time o	
	/Medio		MICHAEL JOSEPE 4a. Facility Name (If not institution		r)		4b. City	, Town, or	Location of	of Death	SEPTEM		, 2005 unty of Death		P ^M
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Le	ocation							10d. Inside C	lity Limits
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	the 28e	Directo	MD QUEEN 10e. Street and Number	ANNE 5	Gr	RASONVI		p Code				10g. Citizen	of What Cou	intry?	
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a L	0 4 4 4		19a. Informant's Name/Relations			1	_				al Route Numb			,	
2	l and fealth m 27 her tr		MICHAEL J. RAD	A, JR./SON	205				BAY D		EAST,				638
E E	m 0		20a. Method of Disposition 1 □ Burial 2 🄀 Cremation			Place of Dispo cemetery, crea FSAPEAR	matory`or	other place	ON		Date	20c. Locati	on - City or T	own, State	
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UNISION	r Atts er de recto by th	Certification:	3 Suicide 6 Could n 4 Homicide determine	inad 286. Place of in	njury - At h	ome, farm, str	eet, factor	y, office			28f. Location (ımber or Rura	al Route Num	iber,
5	Itel o Irs aft rel Di	Cer													
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 2 Certifyin (Check only one)	g Physician: To the bes Examiner. On the basis	ot examina	owledge, deat auon and/or in	h occurred vestigation	at the time	e, date and inion, deal	d place, a	and due to the ed at the time,	cause(s) and date and pla	manner as s	tated. o the cause(s	;)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner s	tated.			c. License					ned (Month,		
)	⊬ ≱ ⊢ 8) Q Q 1	1 Con				7) 3	775	7					
			30. Name and address of person	who completed cause of	death (Iter	m 23a) (Type	Print)	11/1	L/) /	,		01	23-0	J	
			Daniel Juy Konic	K.M.D. 1)	U Lac	2 Point	Rd. :	# 107	. 57	trev	ville, 1	12 11	666		
	Sta		31. Date filed (Month, Day, Year)	32. Regis	rar's Signa	ature		h .			ville, 1				
	Registr	ar	SEP 2	7 2005	due .	K.	Coast	2							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Pau1 Edward Roberts /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner EASTON PITAL THE MEMORIAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months Days 15 M 2 ☐ F Yrs. 235-36-7653 West Virginia Director Aug 23, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28e-1 show the Medical Examiner must be notified at Md Queen Anne's Centreville 1 Tyes 2000No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 3218 Pr 10f. Zip Code Price Station Road 21617 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1948–1952 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🗷 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Plumber** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isham Roberts Bessie Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tree once. Charlotte Ann Roberts / Wife 3218 Price Station Road Centreville, MD. 21617 20b. Place of Disposition (Name of Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 10/3/2005 Stevensville, MD Center, LLC 22. Name and Address of 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A 408 South Liberty Street Centreville, MD 21617 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Caucer Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a noneaquanca of) Examine death certificate be executed burial-tran Due to (or as a consequence of) Completed by Physician/Medical as attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the o 9 Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 ☐ No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? the funeral director 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗌 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David H. Smith, M.d., 29466 Pintail Drive, Suite 5, Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M		d / Depa	artment of F	lealth a	and Me	-	•	
			Registrar 1. Decedent's Name (First, Middle, I	ast)	-,	061	tillcate of	Dealii		Date of Dea	3	3. Time of Death
	Physicia	an	Helen Admonia R						-	Month		Yeer
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location o		Jeropei	4c. County o	1:55 P
	Examin	e:	Buckingham's Ch			ne	Frederi	ick			Frede	erick
	Funeral		5. Social Security Number 6	. Sex 7. Ag		ast birthday)	If Under 1 Year Months Days	If Under:	24 Hrs. 8 Min.	B. Date of Birth (Month, Day	h Year)	Birthplace (State or Foreign Country)
	Director		579-20-5748	1□M 2戻F	106	Yrs.		1.00.0		ec. 29		Indiana
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Manyl 1 sho	ō	Maryland Freder	ick		Adamst	O.M.					1 ☐ Yes 2 ☒ No
	128a	Director	10e. Street and Number	ICK		.ruamb c	10f. Zip Code				10g. Citizen of Wi	hat Country?
	death with the Maryland ms 23a or 28a-f show Firstal be notified at	a D	32 Baker Circle				2	1710			United	States
	ems deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of H	lispanic Orig	igin? (Speci	ify Yes or No-	14. Race Black	- American Indian, , White, etc.
20	hours after tural', or ite	by Fu	1 Never Married 2 Married	If Yes, Give	No	1	1 ☐ Yes 2 ☒ No				l	White
21212-0030	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or items 23a or 28a-f show avent, the Medical Exertil set mat be notified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		16a Dece	dent's Usual Occup	ation			16b. Kind of Bus	iness/Industry
Ċ	within 72 ene. than "nai	Completed	(Specify only highest	grade completed)	F./\	(Give	kind of work done	during most	t of working	7	TOD. TRITO OF DOD	mood madolly
7	d with giene. rr the	mo	Elementary/Secondary (0-12)	College (1-4or 2	5+)		Clerk				Credit	Union
	be filed tal Hygid d other event, t	Be C	17. Father's Name (First, Middle, La								Maiden Sumame)
<u>a</u>	73 - 0 /3	1º	Booker Jefferson							ella G		
Maryland	2 6 5 3		19a. Informant's Name/Relationship Patricia Ranson				ng Address <i>(Street</i> Travener					itate, Zip Code)
d)	1 and 3 Health tem 27		20a. Method of Disposition	/ NIECE	20b. P				, OID			City or Town, State
Baltimore,	G = 0		1 ☐ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State			natory or other place		Octobe	er 8,		
	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lic		ore:		t Cremato 2. Name and Addre		200 ^{ty}	5 1	Saltimore	e, Maryland
ñ	Dep Per		1/1/			R	esthaven 501 Catoo	Funer	ral Se	ervices	s, Skkot	Cody P.A. MD 21701
			23a. Part . Enter the disease, or co	omplications that cause	d the death	n. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				los acc					Onset and Death
	/Medical		resulting in death)	Due to (or as	-							
	Examiner	L	Sequentially list conditions,	Sequentially list conditions, fany, leading to immediate b. Due to (or as a consequence of):								
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	derice or,						
_,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):						
/60,	ysicia ysicia	call		d								
9		Medi	IF FEMALE:									
XOR	ith ce itendii or use	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	death 3	Ectopic pregnancy	y			23d. Date Mont	of delivery th Day Year
	it the dea by the at tached fo	Physician/Med	1 Tes 2 No 9 Unknown	4⊡Pregnant a 9⊡ Unknown	I time of d	eath 5	Other (specify) _					.,,
1	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	/ Ph	Part II. Other significant condition	s contributing to death I	out not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use contrib	bute to the cause of death?
Records,	uires sign	d by								1 🗆 Y	es 2 No 3	3 Probably 4 Unknown
OS OS	w require been signature	Completed								24a. Was	an 24b. W	ere autopsy findings available
He	: The law cate has t	omp								autop perfor	rmed? de	ior to completion of cause of eath? ☐ Yes 2☐ No
Vital		BeC	25. Was case referred to medical					26. Place	e of Death (Check only o	/	
o	hysician: his certific I director,	ToE	examiner?	Hospital: 1 ☐ Inpati		ER/Outpatier	IT 3 DOA		ursing Home	e 5 🗆 Resid	lence 6 Other	r (Specify)
	ding Ph h. After th funeral	inol	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury	Wor			3d. Describe h	low injury occurre	d
Division	tend death stor: /	cat	2 Accident investiga 3 Suicide 6 Could no	t be Ope Blace of In	iury - At ho	ome farm st	M 1 Treet, factory, office	Yes 2		3f. Location (S	Street and Number	r or Rural Route Number,
2	or Attendates death Director: /	Certification:	4 ☐ Homicide determin	ed building, e	tc. (Specif	y)				City or Tow		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	alC	29a. Certifier 11 Certifying	Physician: To the best caminer: On the basis	of my kno	wledge, deat	h occurred at the tir	me, date an	nd place, an	d due to the	cause(s) and man	ner as stated.
	n 24 ha Fu	edical	(Check only 2 Medical Ex	and manner s	of examina tated.	tion and/or in	vestigation, in my c	opinion, dea	ath occurred	at the time, o	date and place, ar	nd due to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier				29c. Licens			:		(Month, Day, Year)
	11		Maur	- MO				587	26		10-6.	-05
	4		30. Name and address of person w					1110	MD 21	773		
	Sta	ite	Yvette Warren, 31. Date filed (Month, Day, Year)	32. 1 gist	rar's Signa	ture	, myersvi	rite,	لک ست	. / / J		
	Registi		31. Date filed (Month Day, Year)	2005	w.	K A	rocks					
	- 22											

		1 - For State Registrar	State of Maryland	/ Depa		lealth and I	Mental Hy	giene Reg. Ng2 () () [36292
Physic /Med		Decedent's Name (First, Middle, Last Kathleen	R	ídeno				r 5, 2005	6:25 A M
Exam	iner	4a. Facility Name (If not institution, give			4b. City, Town, or Silver		h	4c. County of De	
*	ongoig.	Holy Cross Hospit 5. Social Security Number 6. Se		t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	Montgom	ery tirthplace (State or Foreign Country)
Funera Directo			□M 2 ⊠ F 56	Yrs.	Months Days	Hours Min.	June 2	1, 1949 Wa	shington, D.C.
nyland how		10a. State 10b. County	10c. City, 1	fown or Lo	cation				10d. Inside City Limits
Ba-1 e	cto	Maryland Montgon	nery Sil	lver	Spring				1 ☐ Yes 2 X No
with th	Dire	10e. Street and Number			10f. Zip Code	10		10g. Citizen of What	
eath v	erai	2409 Darrow Avenue	12. Was Decedent Ever in U.S.	13.3	2090		pecify Yes or No-	- 14. Race - Ar	nerican Indian,
IIIG Z IZ 13-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural; or items 23a or 28a-1 ehow event, the Medical Exert actional teaching at a	by Funeral Director	12 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ŀ	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2011No		o Rican, etc.)		nite, etc. White
72 ho	ted	15. Decedent's Edi	ucation 1	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation	rkina	16b. Kind of Busines	ss/Industry
d Z I Z I 3- filed within 72 Hygiene. hyperthen "nal ent, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			1)		0 1 0	-
filed w Hygier therth	S	17. Father's Name (First, Middle, Last)	3	Man	ager	19 Mother's Nar	no (First Middle	Condo Co	mbTex
DBILLIMOTE, INIBITY IBING ZIZID-UOSO permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural, or eny holpury optiber traumatic event, the Mazilcal Exam	To Be	Paul Ridenour					Arendt	maiden Samamer	
and and lemma		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ural Route Numbe	er, City or Town, State	, Zip Code)
C, N I and Health mm 27		Sandy Usilton / Si	ister 20h Plac	1181	Stringtow sition (Name of	m Road,	W. Land	caster, Oh	
Baltimore, bermit. Pages 1 ar Department of Hea Importent: If tem eny Injury or other		1 Burial 2 Cremation 3	Removal from State	etery, crei	natory or other place				
it. Pa it. Pa rtmer rtent njury		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Vicense			n Cremato			brentwood ldi Funera	, Maryland
Department		Jan Jan Grand Grand	lu Voi -						ng,MD 20904
Physiciar /Medica	1	23a. Part1. Enter th) disease, or comp shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. one cause on each line. a. Non-Small Ce Due to (or as a consequer	11 Ca					Approximate Interval Between Onset and Death
ificate be executed g physicien and ss the burial-Iransit	icai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pneumonia Due to [or as a consequence. Sepsis Due to (or as a consequence. Chronic Obstitute.	nce of p	ve Pulmon	nary Dise	ease		
HECOTICS, P.O. BOX 050. The law requires that the death certificate the been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 D No 9 Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3[Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
COLDS, P. w requires that the seen signed by should be detailed.		Part II. Dther significant conditions co	ontributing to death but not resulti	ng in the u	nderlying cause give	en in Part I.	2,24		to the cause of death? Probably 4 □Unknown
II HECOTOS, The law requires t cate hes been signe page 2 should be o	Completed							osy prior t rmed? death	
	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only o		es 2 No
	9 8	examiner? 1 Tyes 2 No	Hospital:	VOutpatier	nt 3 DOA Othi	or		dence 6 □Other (S	pecify)
On O	ation: T	27. Manner of Death 1★Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	8b. Time o Injury	Worl	y at k? Yes 2 □ No	28d. Describe h	now injury occurred	
	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, sti	eet, factory, office		28f. Location (S City or Tox	Street and Number or wn, State)	Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in 1	Medical (ysician: To the best of my knowled iner: On the basis of examination and manner stated.						
1	Me	29b. Signature and title of certifier	00		29c. Licensi	e number 52520		29d. Date signed (Ma	
10		30. Name and address of person who o	completed cause of death (Item 2)	3a) (Typa		12720		october J,	2003
		Maria D'Arbela, M				Silver Sp	oring, Ma	aryland	20910
S Regis	tate trar	31. Date filed (Month, Day, Year) OCT 0 7 200	Registrar's Signatur	de	W				

		•	For Stata Registrar	State of N	/laryland	/ Depa		t of H	ealth a	and Me	ental Hy		005	34293
*	Physici		1. Decedent's Name (First, Middle Michael	Rush	1						2. Date of Da Month	ath Day	Year	3. Time of Death 11:40 aum
	/Medic Examin		4a. Facility Name (If not institution Shady Grove	_	r)		-		Location		10/0	4c. Cou	inty of Deat	h
igo,	Funeral Director		5. Social Security Number 577-78-0111	6. Sex 7. A 1 □ X M 2 □ F	Age (In yrs. last 54	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min	8. Date of Bin (Month, Da 5 / 8 / 1 9	th y, Year) 3 5 1		hplace (State or Foreign untry) Iran, Iran
	Maryland		Usual Residence of Decedent 10a. State 10b. County Md. Montg	omery	10c. City, T	own or Lo		3						10d. Inside City Limits 1 ☐ Yes 2X No
	3a or 28a	il Direct	10e. Street and Number 12000 Cheyer	ine Rd.			10f. Zip 208	Code 878				10g. Citizen U . S		untry?
980	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f ehow hadical Exaciliar mast ke nolified at	l by Funeral Director	11. Marital Status 1 Never Married 2 X Marr 3 Widowed 4 Dworced	12. Was Deceder Armed Force ied 1 Tyes 2 the Yes, Give Year or Dates	s? ¶No		Vas Deced i Yes, spec		spanic Ori n, Mexicar Specify:		ify Yes or No lican, etc.)		Race - Ame Black, White ecify: Wh	
Maryland 21215-0036	77 75 75 75	Completed	15. Deceden (Specify only higher Elementary/Secondary (0·12)		,5,\	16a. Deced (Give life. L Owne	kind of woi DO NOT us	rk done d se retired,	luring mos)	t of workin	g	16b. Kind o		Industry ership
yland ;	be filed stal Hyg d othe event,	To Be C		ashidi					Ва	tool		rani	Мо	ghadan
	d 2 sh h and 7 is m traum		19a. Informant's Name/Relations Shohreh Rusi	hip <i>(Type, Print)</i> n – wife			-				Gait			Md.20878
Baltimore,	ges 1 t of t if ite or of		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S			e of Dispo etery, cren klaw				Da 10/8		20c. Location		Town, State
Balti	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service	hast	064						versa .W. W			DC 20011
	Physician /Medical Examiner	Examiner	23a. Part . Enter the disasse, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. PER Due to (or a	as a consequent	EA					respiratory a			Approximate Interval Between Onset and Death
3760,	rate be executed obysician and the burial-transit	ical	resulting in death) Last	Due to (or a	as a consequen	nce of):								
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal de at time of deat	ath 3	Ectopic pr Other (sp					23d.	Date of deli	very Day Year
rds, P.	quires that n signed by uld be deta	ρχ	Part II. Other significant condition	ons contributing to death	but not resultir	ng in the ur	nderlying c	ause give	n in Part I		23e. Did t	1.0		the cause of death?
Il Records,	sicien: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed		100							24a. Was autos perfo 1 🗆 Yes		prior to death?	topsy findings available completion of cause of
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medica examiner?	Hospital: 1 ☐ Inpa		VOutpatien		Othe			Check only o			
of	ing After une	I=	27. Manner of Peal 1 1 Natural 5 Pendir 2 Accident Investi	28a. Date of Ir (Month, L		Bb. Time of Injury		8c. Injury Work	at	28	e 5 Resident			eny)
Division		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place of I	Injury - At home etc. (Specify)	e, farm, str	eet, factory	r, office		2	Bf. Location (S City or Tox	Street and Nu wn, State)	imber or Ru	iral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical one)	g Physician: To the bes Examiner: On the basis and manner	of examination	adge, death and/or inv	estigation,	, in my op	oinion, dea	nd place, ar uth occurre	d at the time,	date and place	ce, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of ceptifie	Tham	Wur	O		License	6 (0°	83		29d. Date sig		
f	-(0)		30. Name and address of person	who completed cause o			Print) D:	r. E	Paul	Thar	nbi			
1	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 7 2	005 Search	strar's Signature	Spar	E)	_,						

		1	FOI	artment of Health and Me rtificate of Death	ntal Hygien	.000 04234					
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) SADIE ROW	VELL 2	Date of Death Month Da	3. Time of Death					
H	Examin		4a. Facility Name (If not institution, give street and number) Fort Washington Hospital	4b. City, Town, or Location of Death Fort Washington	Pr	c. County of Death Pince Georges					
I	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 PF 64 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Date of Birth (Month, Day, Year, 04 17 1	9. Birthplace (State or Foreign Country) 941 South Canolina					
	show		Usual Residence of Decedent 10a. State MD Prince George's 10c. City, Town or Lo Temple H.	ills		10d. Inside City Limits 1 X Yes 2 ☐ No					
	with the N a or 28a-f Le rollifi	<u> </u>	10e. Street and Number 2706 Gaither Street	10f. Zip Code 20748	10g. Ci	itizen of What Country? USA					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mertal Hygiene. Department of health and Mertal Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, It. Medical Francia Innatice ricities a sonce.	by Funeral	Armed Forces?	Use Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Rice 1 ☐ Yes 2 ▼ No Specify:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black					
Maryland 21215-0036	ithin 72 hou ne. nen "nature Nedical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) SISTANT DICKULAN	' .	Rind of Business/Industry Persone					
and 21	d be filed wintal Hygier ed other ti	Be	17. Father's Name (First, Middle, Last) Mack Jones	18. Mother's Name (-					
Mary	nd 2 should Ith and Me 27 is mark r treumation	To	19a. Informant's Name/Relationship (Type, Print) 19b. Maili 19c. Maili 2706	ng Address (Street and Number or Rural F Gaither Street, Temple H	Route Number, City	or Town, State, Zip Code) 20748					
Baltimore,	Pages 1 ar tent of Hea nt: if item: ry or other	15	20a. Method of Disposition 1	matory or other place)	1 .	_ocation - City or Town, State ke View, SC					
Balti	permit. Departminimporte any inju) YUY h	2. Name and Address of Facility ianchi 814 Upshur S		ington, DC 20011					
8760,	death certificate be executed Exam e attending physician and id for use as the burial-transit	Ical Examiner	23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. End Stuge R Due to (or as a consequence of):	CARDIO VASCULAR I		Interval Batween Onset and Death					
.O. Box 68	death certif e attending od for use a	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year					
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Vital Records,	e iaw has b je 2 s	completed			24a. Was an autopsy performed?						
/ital	Physiclen: Th this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (
of	dis dis	lon; To	27. Manner of Death 1 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ant 3 DOA 4 Nursing Home	e 5 Residence	6 □Other (Specify) jury occurred					
Division	s after death. s after death. sf Diractor: After the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	Bf. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)					
	Hospit 4 hour Funer ely fille	edical C	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, deal (Chack only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place, are nvestigation, in my opinion, death occurred	nd due to the cause(d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)					
)	To the within 2 To the complet	Me	29b. Signature and title of dertifier	29c. License number - D0024064	29d. D	Date signed (Month, Day, Year)					
R	(2)		30. Name and address of person who completed gause of death (Item 23a) (Type 514ANDHA HUBBHY 6196 0)	XOX HILRUMD, OXON	9thu, 1	10 20145					
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 7 2005	th)							

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, To the Hospitai or Attending Physicien: erai Director: After ifilled in by the funer within 24 hours e To the Funeral C completely filled

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

29a. Certifier (Check only

Ganti 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Drive Germanteum MD 20874 19529 Doctors 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D41162

29d. Date signed (Month, Day, Year)

October 182005

DHMH 16 Rev 6/95

		1 - State Registrar		aryland /	Depa <i>Cer</i>	artmen <i>tificat</i>	t of H e <i>of L</i>	ealth a Death	ınd M		gieni Reg. No		34296
Physicia	an	1. Decedent's Name (First, Middle, Las. Viola Mae Satter	•							2. Date of Dea Month October	Da	y 2005	3. Time of Death
/Medio Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		octobel		. County of Deal	9:10 A M
		13 Academy Street						Mark				orchest	
Funeral Director		217-03-7319		ge (In yrs. last b 98	Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birt (Month, Da June 12	h Y, Year)	9. Bin 07 Mar	thplace (State or Foreign puntry) y Land
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72 hours after death with the Maryland Insturer, or Items 23a or 28a-1 show digal Exa., free from the notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:	No	1	fYes,spec □Yes :		n, Mexican, Specify:	, Puerto F	Rican, etc.)		Black, White Specify:	e, etc. White
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C 100	Completed	Elementary/Secondary (0-12)	College (1-4or		life. L	o Not us tress	e retired)) "" 9 111031	OI WOIKII	<i>'</i> 9	Cor	mont Ma	ufaaturina
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12 should n and Men rs marke rsumatic		19a. Informant's Name/Relationship (T										or Town, State, 2	Zip Code)
1 and Health Iom 27 other tr		Shirley Satterfiel 20a. Method of Disposition	.d/Daughte	20b. Place	of Dispos	sition (Nan	ne of			Market		D 21631	Town, State
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permit. Pages i Department of t Important: If ite any injury or ot once.		21. Signature of Fund al Service Lic	130	Men	Z-1	Name an eller	d Addres Fun	s of Facility	Home	. P. O.	Во		
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w requires that been signed to should be det		Atrial Fibrillation	<u> </u>							1 🗀 Y	'es 2	No 3 ☐ Pro	obably 4 Unknown
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ital or / rs after at Dire	Certification:	4 Homicide	building, et	c. (Specify)		y	, 550			City or Tow	n, State)	
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	ledicai	29a. Certifier 1	rsician: To the best iner: On the basis o and manner st	f examination a	e, death nd/or inv	occurred a estigation,	at the time in my op	e, date and inion, death	place, a	nd due to the o	ause(s)	and manner as place, and due	stated. to the cause(s)
To the Within To the compli	Me	29b. Signature and title of certifier	(10	P		29c	. License	number		2	29d. Dat	te signed (Month	n, Day, Year)
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		30. Name and address of person who c						, 1	- 0			11/13	
Sta	te	31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	In '	11821	-	Chm	ירוא נ	GM, SC		11415	
Registr	ar	UC 1 1 1	LUUJ A	Section .	0	A Section							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Anna Marie Severn Oct. 5, 2005 5:30a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Fairfield Nursing Home Crownsville Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 □ XT 83 1922 Director Mar. 31, MD 213-12-2986 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show , or items 23a or 28a-f ehov profree rount be notified at 1 Yes 2 No Director Anne Arundel Friendship 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6675 Solomons Island Road 20758 **USA** Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Specify: à 3 XWidowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker International Paper h and Mental Hygie 7 ie marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be i Department of Health and Mental i Important: if Item 27 ie marked of Seymour Gallant Mame Bradley ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Severn/Daughter 6675 Solomons Island Road, Friendship, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Oct. 8, 5 1 Burial 2 Cremation 3 Removal from State Oaklawn Cemetery injury o 4 ☐ Donation 5 ☐ Other (Specify) 2005 Baltimore, MD Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee any. most K 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of); physician Division of Vital Records, P.O. Box 68760 Physician/Medical ettending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the e 9□ Unknown 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Whinknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 2 No 1 Yes 2 **X**0No 1 TYes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Coufd not be 3 🗍 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours a To the Funarei 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Name and address of person who completed cause of gleath (Item 23a) (Type, Print) Clan Burnie MD 21061 Typhway Sw SMA 31. Date filed (Month, Day, Year State Registrar

Michael Lane Simpson 05-07029 Unpend item#25a, Type28a Print in Riack/19deliblesing Finsure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene Reg. 2. U 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MICHAEL LANE SIMPSON October 0 16 2005 7:51 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Yrs 23 Director 233-33-3324 8/10/1982 VIRGÍNIA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at PURCELLVILLE V٨ 1 Yes 2 No Director LOUDOUN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20132 330 SOUTH 20TH STREET USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, the Medical Exameran Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 A 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry LANDSCAPING Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DANIEL SIMPSON SANDRA MABE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL SIMPSON/FATHER 5286 GROVE ST., STEPHENS CITY, VA 22655 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State GERRARDSTOWN PRESBYTERIAN 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GERRARDSTOWN, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee of Address of Facility FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Brown DIOWA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic (Morphine) and Alcohol Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical as IF FEMALE: USB 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ٥ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 X Yes Division of Vital 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 X Yes 2 □ No 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ဥ 28a. Date of Injury 28b. Time of Fnd Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification unk 1 Natural 5 Pending 1 ☐ Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 7:19 A 10-16-05 the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1800 Belmont Ave 4 Homicide Found: Private Dwelling Wodlawn, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 8 2005 Anna Kathryn Springer 6:11 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northampton Nursing Home Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Mar 27, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF 1920 220-05-0427 85 Yrs Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examinations by notified at Maryland Frederick Rocky Ridge 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 9130 Rocky Ridge Road 21778 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 Ia marked othar than "natural", or Ital any injury or other traumatic evant, the Medical Exertities. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No ģ Specify: 3 √Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Factory Worker Business Forms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Marion Havner Bessie Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth L. Cheda/daughter 9130 Rocky Ridge Rd. Rocky Ridge, MD 21778 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 11 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State W. Arundel Crematory 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Lig Going Home Cremation Service P.O. Box 784 M01251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Acute Pulmonary Embolism hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Dectopic pregnancy Month 4☐Pregnant at time of death P.O. F 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Bed Confinement 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕅 No To the Hospital or Attanding Physician: certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deal 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D26499 October 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.G. Ronald Miller M.D. 4 Culwell Drive Mt Airy, MD 21771 31. Date filed (Month, Day, Year) State OCT 1 1 2005 Registrar

			For State Registrar	State	of Marylar		rtment of He tificate of D			iene)5	34300
	Dhusisi	ч	Decedent's Name (First, Middle,	Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic	al	Jo Ann		Suite				Septemb		2005	1534 ^M
	Examin	er	4a. Facility Name (If not institution, Anne Arundel M				4b. City, Town, or L Annapol			4c. County	Arur	ndo1
	Funeral			S. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign
	Director		212-54-3863	1 □ M 2 🗓 F	55	Yrs.	Months Days	Hours Min.	Oct. 7,	1949		ngton, DC
Π	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				10	d. Inside City Limits
	Maryl -faho lieda	tor	MD Anne	Arundel	1	Lothian						1 ☐ Yes 2 No
	th the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	/hat Count	ry?
	ath will	rai	1003 Decesaris				2071			USA		
136	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f ahow aumatic avant, tra Medical Exam our must be notified at	by Funeral	11. Marital Status 1 Never Married 2 XMarrie 3 Widowed 4 Divorced	Armed F	2 XX Vo ive	1	Vas Decedent of Hisp f Yes, specify Cuban, I □ Yes 2X No	Sanic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America k, White, e	
ئ ج	72 hor	eted	15. Decedent's (Specify only highest	Education grade completed)	(Give	lent's Usual Occupati kind of work done du	ion ring most of worki	ing	16b. Kind of Bu	siness/Ind	ustry
Maryland 21215-0036	ould be filed within 72 Mental Hygiene. arked other than "nal atic avant, Ira Medic	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		00 NOT use retired) nistrative	Δeeiets	nt	Stat	e of	Maryland
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lan	Aental Aental rked	To Be	Thurston Willa	rd Adams	3			Marian	Duva11			
lary	s 1 and 2 should I Health and Menitem 27 is marke other traumatic		19a. Informant's Name/Relationshi				g Address (Street an					Code)
	1 and 2 Health		Michael Suite 20a. Method of Disposition	(Husband			Decesaris			, MD 20 20c. Location -		vn. State
nor	Pages nent of thint: If ite iry or of		1 XBurial 2 □Cremation : 1 Donation 5 □Other (Special Contro		State	cemetery, crer	matory or other place) Mem. Gdns			Davidso		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance:		21. Signature of Funeral Service L		I De		Name and Address Hardesty	of Facility Funeral	Home, P	.A.		
	403 4 W		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that	caused the dea	ith. Do not ent	12 Ridge1 or the mode of dying,					Approximate
	Pnysician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_ a		18/	Cardin	Inta				Interval Between Onset and Death
	Examiner			Due to	o (or as a conse	quence of)						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conse	quence of):						
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							-	
8760,	cate be executed physician and the burial-transit	dical Ex	Tosting III down, east	d	(or as a conse	quence or).						
Ó	intificating physe as the	Medi	IF FEMALE:									
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregr birth 2 Fe gnant at time of nown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	y Day Year
Δ	w requires that the been signed by should be deta		Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause given	n in Part I.				e cause of death?
Vital Records,	The law requeste has been page 2 should	Completed							24a. Was a autops perform	ned? d	Vere autop prior to con leath?	sy findings available inpletion of cause of
Vita	Attending Physician: The r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		7500	Other	26. Place of Deat				
	Phys or this oral dii	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	e of Injury	28b. Time o	28c. Injury a	at	me 5 Reside 28d. Describe ho)
ion	inding ath. rr: Afte	ation	1 □Matural 5 □ Pending 2 □ Accident investig	ation	nth, Day Year)	Injury	M 1 □ Ye	es 2 No				
Division of	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could n 4 Homicide determin	18d 289. Plac	ce of Injury - At ding, etc. (Spec		eet, factory, office		28f. Location (Si City or Town	treet and Numbern, State)	er or Rurai	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in the complet	Medical (29a. Certifier 1 Certifying (Check only one)	xaminer: On the	ne best of my kr basis of examin	nowledge, deat nation and/or in	n occurred at the time vestigation, in my opin	e, date and place, nion, death occurr	and due to the cred at the time, d	ause(s) and mai ate and place, a	nner as stand due to	ated. the cause(s)
)	To th To th comp	Me	29b. Signature and little of gertifier	Monde			29c. License	number 446	2	9d. Date signed	(Month, L	Day, Year)
			30. Name and address of e	completed ca	use of death (Ite	ет 23a) (Туре.	rinty	ava	Annip	1	mo	
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 4	2005	Registrar's Sign	the state of the s	who !					

1 - For State Registrar Reg. 40.005 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month **Physician** HELENE W. SCHMELYUN Sept 17 2005 3:00 PM /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** The Pines Talbot Genesis HealthCare -Easton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🛣 F Days Hours 89 Yrs. 215-09-8456 JAN. 26, 1916 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumatic event, If at Medical Evantrer must be notified at 1 ☐ Yes 2 X No Director QUEEN ANNE'S GRASONVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 369 LOBLOLLY WAY 21638 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be f h and Mental h JOEN HAYES FITZMAURICE ANNA MARIE FRITSCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If item 27 la 369 LOBLOLLY WAY, GRASONVILLE, MD BONNIE COVER/DAUGHTER 21638 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
LOUDON PARK
CEMETERY 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any Injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 09/21/2005 BALTIMORE, MD 21. Signature of Funeral Service Licensee Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that detided the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician exebrovesayor years /Medical Due to (or as a consequence of): Examiner Mears teros decosis Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the use as i IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at t be detached fo 4 Pregnant at time of death 5 Other (specify) ☐Yes 2X No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28h Time of 27. Manner of Death After To the Hospitel or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No М 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Momicide within 24 hours a

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completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certification M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIO DUTCHMANS LAND MICHAEL CROWLET MD 32. Registar's Signature 31. Date filed (Month, Day, Year) State Heren & South Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 **Physician** MARION H. SCHUYLER OCTOBER 2005 10:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CORSICA HILLS NURSING CENTER CENTREVILLE QUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X**M 2□F Director Yrs. SEPT.8,1923 MARYLAND 218-30-2172 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23e or 28a-f show Examiner must be notified at Completed by Funeral Director 1 Yes 2 No **GREENSBORO** MD CAROLINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13200 GREENSBORO ROAD, LOT #15 21639 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 📉 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced al Hygiene. Jother than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -0-**FARMER** FARMING perriit. Pages 1 and 2 should be filed v Depirtment of Health and Mental Hygie Important: If item 27 is marked other it any injury or other traumetic event. Ith 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY SCHUYLER LINDA MORRIS P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET BRITTINGHAM/ NIECE 12691 GREENSBORO ROAD, GREENSBORO, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESTERFIELD CEMETERY 10-5-2005 CENTREVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mramia weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions it cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last ue to (or as a consequence of) Box 68760 physician Completed by Physician/Medical the as esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 12 Natural s after dea. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a

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completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10.3.05 DZ5933 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL D. CROWLEY, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601 31. Date filed (Month Co. 32. Registrar's Signature

State Registrar

CHR.	ISTOPHE	R	A. SNEAD For State Registrar		State of	f Marylar	nd / Depa	artmen rtificat	t of H e <i>of L</i>	leaith a Death	and M	ental Hy	giene		34303	
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	Funeral		5. Social Security N	lumber 6.	Sex	7. Age (In yrs.	. last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di	rth	9. Bir	thplace (State or Foreig	gn
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isi	Attending r death.	fica	2 Accident 3 Suicide	6 Could not I	28e. Place	of Injury - At h	nome, farm, str	Hone R		- 7		8f. Location (Street and	d Number or R	ural Route Number,	
Ö	s after s after si Dire	Certi	4 🗌 Homicide		buildin	ng, etc. <i>(Speci</i>	odwa	h-d				Shin 1	wn, State, H.U.	Mear 71	14 SAOW HOLLA	l.
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: / completely filled in by the f	edicai	29a. Certifier (Check only one)	1☐ Certifying P 2☑ Medical Exa	hysician : To the miner : On the ba and mann	isis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim in my op	ne, date an pinion, dea	d place, a th occurre	nd due to the	cause(s) date and	and manner as I place, and due	s stated. to the cause(s)	
	To t To t	Σ	29b. Signature and	title of certifier	11-1			290	. License	number ME				e signed (Mont		
	6		30. Name and add	resent person who	Completed cause	a hidaah (la	m 23a) (Tuna	Brint\ -		~.		1				
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DHMH 17 Rev 1/2001

			FOI	partment of Health and Mental Pertificate of Death		005	34304
	Physi	cian	1. Decedent's Name (First, Middle, Last) SHELZA A. SCOTT	Mon		Year	3. Time of Death 3:44P M
	/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		ounty of Death	
	xa		Suburban Hospital	Bethesda		Montgo	
	Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs. 8. Date (Mon Months Days Hours Min. 711 7	of Birth th, Day, Year) Y 26, 193	9. Birth Cou	place (State or Foreign ntry) Maica
	Directo	1	218-19-2172 Usual Residence of Decedent		720,100		
	arylan show	2	10a. State 10b. County 10c. City, Town of	Germantown			10d. Inside City Limits 1 □Xes 2 □ No
	ith the Marylan or 28a-f show	recto	MD Montgomery 10e. Street and Number	10f. Zip Code	10g. Citize	n of What Cou	
	IIZIS-CUUSO within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Madical Examinat must be notified at	Funeral Director	19144 Highstream Drive	20874		U.S.A	•
	after deat or items?	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 	or No- c.)	Race - Ameri Black, White	
9	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	S	pecify: Bl	ack
6	Z1Z13-0U30 d within 72 hours aff giene. er than "natural; or tha Madical Exami	ted	15 Decedent's Education 16a D	ecedent's Usual Occupation	16b. Kind	of Business/Ir	ndustry
3	Men "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired) Seamstress		priva	te
Ċ	filed v Hygie other t	ပိ	12th 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	fiddle, Maiden Si	umame)	
1	Vian Uid be Mental rked c	To Be	George Denton	Jane Hud	son		
	IlTIMOTE, MATYIANG ZIZID-UUSO int. Pages 1 and 2 should be filed within 72 hours aft artment of Health and Mental Hygiene. ortant: If them 27 is marked other than "natural", or injury or other traumatic event, the Madical Exami			ailing Address (Street and Number or Rural Route and Highstream Dr Ge			
	e, R 1 and Health em 27		011111	isposition (Name of crematory or other place)		ition - City or T	
	ages ent of ht: If it		Parallel 2 Cremation 3 Memovarirom State		05 Si	lver S	pring, MD
<u> </u>	Baltimore, permit. Pages 1 ar Department of Hea Important: If them any injury or othe	ouce.	21. Signature of Funeral Service Licens	22. Name and Address of Facility Snowd	en Fuer	nral E	lome, PA
	Ded die	ă z	early Deloide	246 N. Washington S		AITTE,	
			23a. Part1. Enter the disdase, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final		tory arrest,		Approximate Interval Between Onset and Death Days
	Physicia /Medica		Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPT Due to (or as a consequence of)		·	-	Dayo
7	Examine		Sequentially list conditions, b. HEPATIC HEMAI				Days
74	ted sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ABDOMINAL COM	PARTMENT SYNDROME			Days
5	60, be executed sician and burial-transit	Ехаг	that initiated events resulting in death) Last C. Due to (or as a consequence of)				
	8760 ate be e hysician the buris	Ical	d				
50	BOX 68 leath certifica attending ph	Physician/Medical Examiner	IF FEMALE: 23c. If yes, outcome of pregnancy		22	d. Date of deliv	roo.
	Beath cert seattending of for use	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
02	at the de de de de de de de de de de de de de	hys	9 Unknown				
2	1S, F	5	Part II. Other significant conditions contributing to death but not resulting in the Multi organ sysytem failure,		Did tobacco use		the cause of death? bably 4 Unknown
_	COTC A requir been si should	letec					
	VITAI RECOTO ician: The law requir certificate has been si	Completed	Atelectasis	10	autopsy performed? Yes 28 No	prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
20	VITAL F sicien: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death Check	only one)		
	Of V Physic rthis or ral dire	ုင	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp	atient 3 DOA Cther: 4 Nursing Home 5	Residence 6 (fy)
	on on on oding Fig. : After of funering and other of the original of the origi	tlon	27. Manner of Death 1 Manural 5 ☐ Pending 2 ☐ Accident investigation 28b. Tin (Month, Day Year) lnju		onbo now injury	30001160	
	Division I or Attending after death. Director: After Jin by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 28f. Loca City	tion (Street and or Town, State)	Number or Rui	al Route Number,
产	Dital o	Ce	29a. Certifier 12 Certifying Physician: To the best of my knowledge,	death accurred at the time, date and place, and due	to the cause(s) a	ad manage as	etatod
Scott,	DIVISION Of VITAI RECONDS, P.O. BOX 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one) 2 Medical Examiner: On the basis of ray knowledge, (Check only one)				
0,	To the within : To the	×	29b. Signature and title of certifier	29c. License number		signed (Month	
	2		· Saima Khawaja,	- 000000	00	tober	2, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Ty Saima Khawaja, MD 11119 Rocks	•	ckville	e. MD	20852
		State	31. Date filed (Month, Day, Year) 32 Registrar's Signature	Speak)		,	 -
	Regi	strar	OCT 0 7 2005				

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			1 - For State Registrar	State of N	Maryland		artment rtificate			and M	lental Hy	giene Reg. No!	111	05	34	306
	Physici	an	1. Decedent's Name (First, Middle, La	ist)							2. Date of D Month	eath Day	,	Year	3. Time	of Death
	/Medic			Mitchell Mitchell		on					Octobe	er 13	20	005	1020	AM
	Examir	ner	4a. Facility Name (If not institution, gir		r)		4b. City, To		Location of	of Death		1	_	y of Death ∴ 1	ı	
	E		SunBridge Care 5. Social Security Number 6.		Age (In yrs. la	st birthdav)	E1kt		If Under	24 Hrs.	8 Date of B	1	Cec		nlace (State	or Foreign
Н	Funeral Director			1 X 1M 2□F	85	Yrs.	Months		Hours	Min.	8. Date of B (Month, D APR 29	ay Year)	20	Mary	place (State intry) land	or r oreign
	р. 		Usual Residence of Decedent		10.00											
	anyla	5	10a. State 10b. County			Town or Lo	cation								10d. Inside (City Limits s 2 ∏ No
	the M	ecto	Maryland Cecil 10e. Street and Number	-	E1	.kton	10f. Zip C	'ada				10a Citi		What Cou		X
	With Se or	급	22 Kent Road				219							ed St	-	
	death ms 2:	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13.			spanic Orig	gin? (Spe	acify Yes or N Rican, etc.)		14. Ra	ce - Ameri	can Indian,	
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f ahow evant, it e Madical Exacting must be natified at	by	1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 [X]Yes 2 [If Yes, Give Year or Date:	√War T	,	fYes, specif 1☐ Yes 2[, Puerto	Rican, etc.)		Bla Specif	ick, White, ^{fy:} Wh:	etc. ite	
Maryland 21215-0036	72 ho natur	eted	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Usual kind of work	Occupa	tion	t of work	ina	16b. Kii	nd of B	Business/Ir		
7	athin be.	Completed	Elementary/Secondary (0-12)	College (1-4d	r 5+)	life.	DO NOT use	retired)		O WOIN	ng .					
2	filed w Hygier othar ti		8 17. Father's Name (First, Middle, Las	1		Pi	pe Fit			de Nome	(Friend & Sindal)			road		
anc		Be (Olaf Swanson	/							e (First, Middle nelia F			me)		
چ	d 2 should by the and Menta 7 la markad traumetic evenue.	T _o	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a			I Route Numb			State Zi	n Code)	
<u> </u>	12: h ar 7 la trau		Rebecca R. Swar		1						Mary1a			,	, ,	
Baltimore,	of Horitan		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 ↑ 4 □ Donation 5 □ Other (Special Control of the Con		20b. Pla	ce of Disponentary Crei	sition (Name natory or oth LE	of er place)	Octo	ber	20c. Lo	cation	- City or T	own, State	11
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice		Cone	ceptio H	on Cem Name and LCKS H	ete: Addres: OMe	ry s of Facility for	l8, 2 Fune	rals, l eet, E	Cher P.A.	ry	нтт	, Mary	land
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caus	ed the death.	Do not ent	or the mode	of dving	kton such as	Str	eet, E.	Lkton	, M	aryla	and 21 Approxima	
4	Physician	1	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ISCHE							n rospilatory t	arrest,			Interval Be Onset and 3 4EA	tween Death
	/Medical Examiner			b. CO KO L											24E	74125
/	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. PLEUR	AL E	FFUS									148	472
,092	te be executed ysician and he burial-transit	cal Ex	resulting in death) Last	Due to (or a	as a conseque		COL	لرو							14EH	R
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dat time of dea	leath 3	Ectopic preg					2		ite of deliver	-	Year
<u>.</u>	that ti ed by detac		Part II. Dther significant conditions	contributing to death	but not result	ing in the u	nderlying cau	se give	n in Part I.		23e. Did	tobacco u:	se cont	tribute to t	he cause of	death?
d Q	uires I sign Id be	d by					, ,				1 🗆	Yes 2	□No	3 ☐ Prot	oably 4 🗷	Unknown
S	w require been si should I	Completed									24a. Was	s an	24b	Were auto	psy findings	available
Re	The lav	omp									auto perfe	psy ormed?		prior to co death?	mpletion of	
Vital Records,		a)	25. Was case referred to medical	ACCESSOR					26. Płace	of Death	1 Yes			1 □ Yes	212 No	
	d si	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 El	R/Outpatien	t 3 DOA	Othe			ne 5□Res		Oth	ner (Specif	(y)	
ion of	Itel Inel		27. Manns of Death 1 Natural 2 Accident 5 Pending investigation	28a. Date of Ir (Month, L	ijury 2 Day Year) 2	8b. Time of Injury	28d	: Injury Work'		4	28d. Describe					
Division	al or Attandii s after death. sl Director: A sd in by the tu	Certification:	3 Suicide 6 Could not l 4 Homicide determined	288. Place of	njury - At hom etc. (Specify)	e, farm, str	eet, factory, o	office		1	28f. Location (City or To	(Street and wn, State)		oer or Rura	al Route Nur	nber,
	To tha Hospital or Atta within 24 hours after de To tha Funarel Directo completely filled in by th	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the bearings: On the basis and manner	of examinatio	edge, death on and/or in	occurred at restigation, in	the time	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and ma place,	anner as s and due to	tated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	, ,			29c. 1	icense	number			29d. Date	signe	d (Month,	Day, Year)	
	, , \		I Inlamble	· his	li			00	746	3		10-	-13	1-0	5	
3	X \		30. Name and address of person who Rolando A. Najera	n, M.D., 1	.38 Cat	hedra		et,	E1kt	on,	Maryla	nd 21	921	L		
1	Sta Registi		31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu	re	١.									
DH	ИН 17 Rev 1/2	001	007 2 1 200	Alexan	· B.	SIGIN.	25									

	•	State of Maryl	and / Depa	artment of Health and rtificate of Death	Mental Hy	-
Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Elizabeth Agnes Trego			2. Date of De Month	ath Pay Year 3. Time of Death 10 30 PM
Examine		4a. Facility Name (If not institution, give street and number) Chesapeake Woods Center		4b. City, Town, or Location of Dea Cambridge		4c. County of Death Dorchester
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (In 74 Usual Residence of Decedent	yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir	8. Date of Bird (Month, Da March 2	9. Birthplace (State or Foreign Country) 0,1931 Mary Land
the Maryland 28a-f show polified at	20		City, Town or Lo			10d. Inside City Limits 1 X Yes 2 □ No
death with the ms 23a or 28a	al Direc	10e. Street and Number 115 Temple Street		10f. Zip Code 21664		10g. Citizen of What Country? USA
nd 21215-0036 (C.C.) I flied within 72 hours after death with the Marylar other than "natural", or flams 23a or 28a-f show yent, the Majeri Experienments notified at the Majerial Experienment of the Completed by Emperal Director	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene 73 Is marked other than "natural", or traumatic event, the Modell Exami	paraldur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 1		dent's Usual Occupation kind of work done during most of w DO NOT use retired) Ceria Worker	orking	16b. Kind of Business/Industry County School
Baltimore, Maryland 21215-0 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natur any joilury or other traumatic event, Ile Motel ange.	9	17. Father's Name (First, Middle, Last) Joseph Nathaniel Moxey		18. Mother's N	ame (First, Middle, Katheri	Maiden Sumame)
, Mary and 2 sho salth and n 27 is my iar traum		19a. Informant's Name/Relationship (Type, Print) Thomas W. Trego/Husband	P. C	ng Address (Street and Number or F). Box 36, Secret	ary, MD	-
Baltimore, Mar permit. Pages 1 and 2 st Department of Health and Important: If item 27 is nr any injury or other treum once.		I Dunai 2 10 Cientation 3 Deninovalitom State		sition (Name of natory or other place) of Delmarva 10/8	Date / 2005	20c. Location - City or Town, State Delmar, Delaware
Balt permit. Departr imports any inj		21. Signature of Funeral Service Licenses	Ze 10	Name and Address of Facility Liler Funeral Hom Ob Main Street, E	ne, P. O. Last New	Box 207 Market, MD 21631
Physician /Medical Examiner		resulting in death)	fail	lure		Approximate Interval Between Opset and Death
3760, ate be executed systician and he burial-transit	ical Ex	Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY Due to (or as a cor d. COVOY D. COVO	asequence of): asequence of): asequence of):	mellitus artery dis	sease	10 years
P.O. Box 68760, that the death certificate be executed ed by the attending physician and detached for use as the burial-transit blussicial fixantical Example.	riiysiciali/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P.O. he law requires that the e has been signed by the sge 2 should be detache	red by ri	Part II. Other significant conditions contributing to death but not hypertension,	resulting in the un	, , ,		obacco use contribute to the cause of death? 'es 2 \sum No 3 \sup Probably 4 \sum onknown
The law ate has be page 2 s	completed by				24a. Was autop perfor 1 Yes	sy prior to completion of cause of med? death?
vision of Vital F Attanding Physician: Th r death. y the tuneral director, pag	2	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	2 ER/Outpatien 28b. Time of Injury	t 3 DOA Other: 4 Nursing		ne) lence 6 Other (Specify) low injury occurred
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Ceruncanon	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (Sc	At home, farm, streecify)	eet, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, m, State)
in 24 hour ha Funer. pletely fills	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my 2 Medical Exeminer: On the basis of examinand manner stated.	knowledge, death nination and/or inv	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the durred at the time, d	cause(s) and manner as stated. Jate and place, and due to the cause(s)
To the within To the comp	N.	29b. Signature and title of certifier AU AU AU AU AU AU AU AU AU A	_	29c. License number + + + + + + + + + + + + + + + + + + +	3 1	29d. Date signed (Month, Day, Year)
		30. Name/and address of person who completed cause of death Patricia Johnson	(Item 23a) (Type,	Print) ramble St, Ca	mbrida	ge, m02/6/3
State Registrar		31. Date filed (Month, Day, Year) OCT 1 1 2005	ignature	South	•	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U 0 5 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2005 4:00 OCTOBER SAUNDRA J. TAYLOR /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS 2022 GOV. THOMAS BLADEN WAY, #302 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number **Funeral** 1 ☐ M 2 🕅 F 62 Director 173-34-2810 MAR. 6, 1943 PA Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2022 GOV. THOMAS BLADEN WAY, #302 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or tles any injury or other traumatic event, the Medical Estim 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOBILE SECRETARY 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ALTA MCINTYRE MILES E. HANEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 NEW YORK AVE., PUNXSUTAWNEY, PA WM. PERRY MCKEEN/STEP-BROTHER 20b. Place of Disposition (Name of cometery, crematory or other place)
CHESAPEAKE CREMATION
CENTER, LIC. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/03/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or comblications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer ear **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month jo in the past 12 months?
1 ☐ Yes 2 ▼ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 X No 1 ☐ Yes 2 ☐ No 1 Yes Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 4 hours after deam.
Funeral Director: After this c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury or Attanding 5 Pending 1 X Natural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier H0055542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 888 Bestgate Rd Annapolis 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1- For State of Maryland / De Registrar	partment of Health and Mer ertificate of Death	ntal Hygiene 005 343	09
	Physici /Medic		Decedent's Name (First, Middle, Last) MODESTO A. TECSON		Date of Death Month TOBER 5, 2005 A Time of 10:10P	
	Examir		4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL	4b. City, Town, or Location of Death FORT WASHINGTON	4c. County of Death PRINCE GEORGE'S	
	Funeral Director		5. Social Security Number 215–35–8939 Usual Residence of Decedent 6. Sex 1 M 2 F 81 7. Age (In yrs. last birthof yrs.) Vrs. 1 Vrs.	y) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. Ju	Date of Birth (Month, Day, Year) 1y 17, 1924 Philippines	r Foreign
	ith the Maryland or 28e-f ehow	Director	10a. State 10b. County 10c. City, Town of Maryland Prince George's Fort Wash. 10e. Street and Number	ngton 10f. Zip Code	10d. Inside City 1 ☐ Yes 10g. Citizen of What Country?	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f ehow any injury or other treumetic event, the Madical Examinar must be notified at ance.	by Funeral Director	8707 Dover Street 11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	20744 3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rice 1 □ Yes 2 ☒ No Specify:	Philippines y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc. Specify Asian/Filipin	10
Maryland 21215-0036	ed within 72 hoygiene. 190 year than "natu 10 the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) Self-	cedent's Usual Occupation ve kind of work done during most of working DO NOT use retired) -employed	16b. Kind of Business/Industry Barber	
aryland	d 2 should be filed within in and Mental Hygiene. 7 Is marked other than "reumetic event, the Mag	To Be	17. Father's Name (First, Middle, Last) Enrique Tecson 19a. Informant's Name/Relationship (Type, Print) 19b. M	Celestina A	dvincula oute Number, City or Town, State, Zip Code)	
Baltimore, M	ii. Pages 1 and 2 intment of Health ortent: If item 27 njury or other tru			Dover St. Ft. Washington, position (Name of rematory or other place) attory 10/7/2005	20c. Location - City or Town, State Fdgewater, MD.	
Ba	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not shick, or heart failur. List only one cause on each line. Immediate Cause (Final disease or condition Find Stage Congestive	6160 Oxon Hill Rd. Oxon Higher the mode of dying, such as cardiac or re-	ill, Md. 20745	veen leath
,8760,	/Medical Examiner be executed bulksician and stree burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Each Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Med		B□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Ye	ear
Records, P.	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the Cardiomyopathy	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de	ath?
al Rec		Completed	OS Was associated to market	-	24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings an prior to completion of cardeath? 1 ☐ Yes 2 ☐ No	vailable use of
sion of Vital	ding Phys n. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident Positive Response Personal Response Provided Provid	of 28c. Injury at 28d.	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred	
Division	in Dir	i Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Location (Street and Number or Rural Route Numb City or Town, State)	oer,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, d. 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier	ath occurred at the time, date and place, and investigation, in my opinion, death occurred a 29c. License number	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 1.0/6/05	
_	(3)		30. Name and address of person who completed cause of death (Item 23a) (Tyl Rointan Farahifar, M.D. 9801 Georgia Ave. Sil. 31. Date filed (Month, Day, Year) 42. Registrar's Signature	ver Spring,MD. 20902		
	Regist		OCT 0 7 2005 Red & Co	A.		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death J Day **Physician** Month MICHAEL DICKINSON WARD SEPTEMBER 30,2005 3:55 ₽^м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLTS
If Under 1 Year | If Under 24 Hrs. ANNE ARUNDEL **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1√2 M 2□ F Hours 579 64 2823 Director 58 Yrs. SEPT.09,1947 MARYLÁND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Completed by Funeral Director 1 ☐ Yes 2 No MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8723 BLAIRWOOD ROAD APT.4B 21236 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No traumatic event, the Medical Examiner of Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2√2 No Specify: WHITE 3 Widowed 4 Divorced naturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 TRUCK DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES JOSEPH WARD ဂ္ NANCY ANN LANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) othar t NANCY A. WARD BALTIMORE MD. (SISTER) 1104 KENILWORTH DRIVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. KALAS CREMATORY * 4 ☐ Donation 5 ☐ Other (Specify) EDGEWATER, MD. 10-02-05 22. Name and Address of Facility GEORGE P. KALAS FUNERALHOME 21. Signature of Finisiral Saurice 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD, 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 01 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificete be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 2 1 ☐ Yes 2 ☐ Mo npatient 2 ER/Outpatient this 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1- Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

- V (Check only one) 29b. Signature and title of 30. Name and ad less of person who completed cause of death (Item 23a) (Type, F Ga Ridgely Ave

·Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 0 4 2005

1001610

istrar's Signature

State of Maryland / Department of Health and Mental Hygiens 0 0 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 18 2005 7:00 a ^M **Physician** OCTOBER AMY L. WALLS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sudlersville
If Under 1 Year | If Under 24 Hrs. 100 Linden St. Queen Anne's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 10 19 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2₩F 85 Yrs Director 214-32-2461 Usual Residence of Decedent 1920 Delaware 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at Director 1-Yes 2 No MD Queen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "naturel", or Items 23e 100 Linden St. 21668 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Iten eny Injury or other traumatic event, the Medical Examines one. Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Cahall Florence McGinnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Dukes (daughter) P.O. Box 152 Sudlersville, MD. 21668 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cem. 10/22/05 Centreville, MD. 21. Signature of Fureral Service licensee 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 No the 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by CORONARY ARTERY 1 Probably 4 Unknown Be Completed PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? autopsy PERLIPIDEMIA performed? certificate Division of Vital 1 Yes 1 ☐ Yes 2 No 2 No Hospital or Attending Physicien: 25. Was case referre to medical 26. Place of Death Check onl one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♣ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural ospitar c. 4 hours after dea... rel Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 2540 Centreville Rd. Centreville, MD. 21617 Eric F. Ciganek, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		Please I	ype or Print in t			•	•			
		1 _ For State	State of Marylan		nt of Health and l te of Death					
		Registrar 1. Decedent's Name (First, Middle, Last)		Certifica	e or Death	2 Date of Death	3. No.2 0 0 5	31100 000002		
Physi /Med	lical	Marsha A.	. William		Town or Logation of Dogst	Month C	Day Year 4c. County of Dea	- 442Anvi		
Exam	iner	4a. Facility Name (If not institution, give s	Li lake) D. City	Town, or Location of Deat	MD	11 11 (2)	m i ∞		
Funera	al	5. Social Security Number 6. Sex	7. Age (In yrs.	Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Bir	thplace (State or Foreign ountry)		
Directo	r	Usual Residence of Decedent	^M 2 ^C F 82	Yrs.		Jan. 10,	1923 ME) ''		
rland ow		10a. State 10b. County		y, Town or Location				10d. Inside City Limits		
Man a-feh	ctor	MD Worceste	r Ocea	ın City				1 X Yes 2 □ No		
death with the Maryland ma 23a or 28a-f ehow rmest be notified at	Director	10e. Street and Number			p Code		g. Citizen of What Co	ountry?		
eath w	erai	11204 Coastal Hig	hway 2. Was Decedent Ever in U		842		V Yes or No- 14. Race - American Indian,			
fter d	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗡 No If Yes, Give	If Yes, spe	dent of Hispanic Origin? (Secify Cuban, Mexican, Puerl 2X No Specify:	o Rican, etc.)	Black, Whit	te, etc.		
ING Z1Z13-UU30 be filed within 72 hours after death with the Marylar tal Hygiene. d other than *natural; or itema 23a or 28a-1 ehow event, tra Medical Examinat must be notified at	d by	3 X Widowed 4 ☐ Divorced		Specify: Whi	rte					
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L Within 72 liene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Owner			Apartment	Building		
id be filed ental Hygin ked other ic event, it	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Ma	aiden Sumame)			
	10	Charles Buntin								
Mar d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (Type Cynthia Leigh Gian	· ·		s (Street and Number or Ri hwest 97th Wa		•			
		20a. Method of Disposition		Place of Disposition (Na emetery, crematory or			Oc. Location - City or			
Pages nent of unt: If its		1) Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			ial Park 10-9	9-2005 E	Berlin, Ma	aryland		
Baltimore, pemit. Pages 1 at Department of Hea Important: If item	9	21. Signature of Funeral Service License	ө		nd Address of Facility T			Home		
n gaes	ä	Mi Yel Du	elage		William St.,			1 According to		
T		23a. ant1. 2016 dise vs., or complice shock, or leart filter. List only on Immediate Cause (Final	cations that caused the deat e cause in each line.			or respiratory arres	t,	Approximate Interval Between Onset and Death		
Physicial /Medica		disease or condition resulting in death)	Due to (or as a conseq		udant			one month		
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xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
X b8/bU, certificate be executed iding physician and use as the burial-transit	calE	U d								
og ph as th	Medi	IF FEMALE:								
death ce death ce attendii	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Feta	Ideath 3□Ectopic (23d. Date of de Month	livery Day Year		
. 0 0 0	ysic	1 ☐ Yes 2 ☐ Ño 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5 Other (s	pecify)			,		
d bear	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute to	o the cause of death?		
w requires to been signed should be	ed b					1 ☐ Yes	2 No 3 P	robably 4 🗍 Unknown		
S E S	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of		
VITAI KE sician: The la certificate ha: irector, page 2						performe 1 □ Yes 2	ed? death?	2540		
	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:atient 2 🗆	ER/Outpatient 3 D	Othor	ath Check only one	ce 6 ☐Other (Spe	-a/4.1		
	n; To	27. Manner of Death	28a. Da e of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		эспу)		
VISION Attending In death. ector: After by the funer	atio	Natural 5 Pending investigation 3 Suicide 6 Could not be	(Monn, Day Tour)	M	1 ☐ Yes 2 ☐ No					
	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto y)	ry, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,		
DI To the Hospital or To the Funaral Di completely filted in		29a. Certifier Certifying Phys	ician: To the best of my kno	owledge, death occure	d at the time, date and place	, and due to the cau	use(s) and manner a	s stated.		
n 24 h ha Fu pletely	Medical	(Check only 2 Medical Examinone)	er: On the basis of examina and manner stated.	ition and/or investigation	n, in my opinion, death occu	irred at the time, dat	e and place, and due	e to the cause(s)		
To the within 2 To the	Σ	29b. Signature and title of certifier	111)		c. License number		d. Date signed (Mont			
C,H,		MUC		M()	D2627	8	10-7-	05		
)		DANDE (LALA, W.		n 23a) (Type, Print)	D2627	Salssi	4 run	21852		
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			1 - For State of Maryland / Department of State of Maryland / Department / De	artment of Health and Mer rtificate of Death		ene	31.313	
*	q		Decedent's Name (First, Middle, Last)		Date of Death	Star C C C	3. Time of Death	
	Physici /Medi		Genevieve Mae Wharton	Oc	Month tober (5 2005 Year	11:10 a M	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat		
			Calvert Manor Healthcare Center	Rising Sun		Cecil		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 222-01-6603 1 M 2 XF 91 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. Au	Date of Birth (Month, Day, 1) 1gust 9	(ear) 9. Birth Co 1914 Del	nplace (State or Foreign untry) aware	
	put		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lor	antina			404	
	aho	5					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	28a-1	ect	Maryland Cecil Rising Su	n 10f. Zip Code	140	- Ciri ()A/L A	Λ	
	with Be or		1881 Telegraph Road	21911		g. Citizen of What Co Jnited Sta	•	
	ns 23	era		Vas Decedent of Hispanic Origin? (Specify		14. Race - Ame		
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural" or items 23a or 28a-f ahow event, i're Medical Evanting roual be routlied at	Completed by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Yes, specify Cuban, Mexican, Puerto Rici	an, etc.)	Black, White Specify: Whi	e, etc.	
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21	thin 7	ple	(Specify only highest grade completed) (Give life, L	kind of work done during most of working OO NOT use retired)				
2	e filed within at Hygiene. I other than vent, the Ne	Con	8 Homem	aker	(Own Home		
Maryland	al Hygie d other event,	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	irst, Middle, Ma	aiden Surname)		
Va	es 1 and 2 should be fi of Health and Mental H fitem 27 Is marked ot r other traumatic ever	2	Unknown	Gilda Mae	Savage	2		
ar			19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rural Ro	oute Number, (City or Town, State, Z	lip Code)	
	and ealth m 27		Gene Ragan/ Daughter 2465	Theodore Road, Nort	h East,	Maryland	21901	
Baltimore,	of H of H if ite		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	sition (Name of natory or other place) October	10. 20	c. Location - City or	Town, State	
Ē	permit. Pages 1 Department of H Important: If ite any injury or ot once.		`4 Donation 5 Other (Specify) North Eas	t Methodist 2005		North East Maryland	,	
Salt	permit. Depart Import Import any inj		21. Signature of Emeral Service Licenses 22.	. Name and Address of Facility Crouc	h Funer	al Home		
_	20599		12	7 South Main Street	, North	East, Ma	ryland 21901	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	or the mode of dying, such as cardiac or re	spiratory arres	t,	Approximate Interval Between	
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	Dementia				
			Sequentially list conditions, b. Failure for	Thrive				
	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	,				
	and -tran	каш	that initiated events resulting in death) Last					
8760,	icate be executed physician and s the burial-transit		Due to (or as a consequence or):					
87	physic the	dlcal	d					
9 X	requires that the death certific een signed by the attending p hould be detached for use as	lcian/Me	IF FEMALE: 23c. If yes, outcome of pregnancy					
Вох	atten for u	ian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	very Day Year	
0	at the de by the stached	Physic	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)				
Ω.	that ed by deta	/Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
ds	sign sign	d by			1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown	
Ö	w requir been si should	Completed			04- 146			
Re	e s e s	d E			24a. Was an autopsy performe	d? vvere aut prior to e	opsy findings available ompletion of cause of	
Vital Records,	ian: The rtificate ctor, pag		OF INC.		1 ☐ Yes 2 5	No 1 ☐ Yes	2DNo	
\$	9 9	Be c	25. Was case referred to medical examiner? 1 Yes /2 No Hospital: 1 Innation 2 EB/Outnationt	26. Place of Death (Cl				
ō	Phys r this ral di	: To	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA Nursing Home		e 6 Other (Specinjury occurred	ify)	
on Se	ding th. Afte fune	tlor	Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 Yes 2 No		injury occurred		
División	Attanding ir death. ector: After by the fune	flca	3 Suicide 6 Could not be 28e. Place of Injury - At home farm stre	eet, factory, office 28f.	Location (Stree	at and Number or Rur	ral Route Number.	
合	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)		
	To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director: Atler this completely filled in by the funeral.		29a. Certifier Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	due to the caus	se(s) and manner as	stated.	
	e Ho 1 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or involute and manner stated.	estigation, in my opinion, death occurred a	it the time, date	and place, and due	to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)	
			DARREST MIS	DOP168	1	2/10/05		
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)				
			M. JOKHADAR 281 E. Main St.	29c. License number DON 168 Print) Rising Sun, Mi	219	911		
• :	Sta	te	31. Date filed (Month OC Year) 1 2005 32. Registrar's Signature					
	Registr	ar	Marine St /	back				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 25, 2005 8:32 A^M BERTHA BAILEY WALKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Director 88 Yrs. 212-03-2671 IN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 238 431 WALKER ROAD 21666 USA tams 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after did Hygiene.
other than "natural", or itam 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE þ Specify: 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 REGISTERED NURSE MEDICAL other parmit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any liquy or other traumatic event 9008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLYDE BAILEY **NELLIE BAUSMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM W. WALKER, JR./SON 431 WALKER RD., STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
LORRAINE PARK
CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 09/29/2005 GWYNN OAK, MD 21. Signature of Furreral Service L Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause/on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cerebrovascular day /Medical Due to (or as a consequence of): **Examiner** Hypertension Duatol(or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 🗌 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lalew 40 D0055127 erson who completed cause of death (Item 23a) (Type, Print) 130 Love Point Road Ste 107 Stevensville MD and Margare 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State SEP 2 8 Registrar

			1 - For State Registrar	State of Ma	aryland	d / Depa	artmen	t of H	ealth a		ntal Hygi	ene 200		01015
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Cei	tificat	e or L	Jeath	2	Re-	g. n 2. 0 0	J	34315 3. Time of Death
П	Physici /Medio		HAZEL G	WHALEN							Month Oct. 4	Day	Year	10:10A ^M
	Examir		4 = 100 44 100 11 10 10 11 11 11 11 11 11				4b. City, Town, or Location of Death Derwood					4c. County of Death Montgomery		
É	Funeral Director		5. Social Security Number 6. S		e (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2	Min.	Date of Birth (Month, Day,	, 1915	9. Birtho Cour Mar	place (State or Foreign http:// yland
	and I		Usual Residence of Decedent 10a. State 10b. County			, Town or Lo	cation							Od. Inside City Limits
	se Mary Be-f sho	ctor	MD Montge	omery]	Derwo	od							1 AYes 2 □ No
	with th	Dire	10e. Street and Number 7300 Needwood	Pond			10f. Zip	Code	2085	5.5	10	g. Citizen of W	hat Cour	•
	death	nera	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13. V	Was Deced	lent of His	spanic Origi n, Mexican,					an Indian,
036	should be filed within 72 hours after death with the Maryland nid Mental Hygiene. Ind Mental Hygiene. In marked other then "naturel", or Items 23a or 28e-f show marked other then "naturel" or Items 21a or 28e-f show umatic event, it a Madical Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 14 If Yes, Give Year or Dates:	No		Tes, spec		Specify:	Ривпо ніс	an, etc.)	Specify:	Bla	
5-0 -0	"natur	leted	15. Decedent's Ec (Specify only highest gra	lucation de completed)		16a. Deced	tent's Usua kind of wor	l Occupa k done di	tion uring most o	of working	10	6b. Kind of Bus	siness/In	dustry
212	d withir giene.	omo	(Specify only highest grade completed) Elementary/Secondary (0-12) 10th (Give kind of work done during most of working life. DO NOT use retired) Privat								:e			
Maryland 21215-0036	lbe file ntal Hy ad othe : event,	Be	17. Father's Name (First, Middle, Last)						18. Mother		irst, Middle, Ma Lrude		,	
aryl	should and Me a mark umatic	٦ ک	Joseph Snow			19b. Mailin	g Address	(Street a	nd Number	or Rural Ro	oute Number,	City or Town, S	State, Zip	Code)
S O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Marked Examinet must be notified at once.		Laurene Thoma	s-Daught					od Ro		cwood,			
nor			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Ce	ace of Dispo- metery, cren Memo	natory or o	ther place		Date 0/7/2		Oc. Location - C	•	oring, MD
Baltimore,	porter porter y injur		21. Signature of Funeral Service Licen		ASII	_							_	ome, PA
<u>m</u>	89 8 9		Course !	Sin	de	N 24	16 N	Was	hing	ton S	St Roc	kville		20850
	Physician		23a. Part 1. Enter the disease, or com shock, or hear vailure. List only Immediate Cause (Final disease or condition			ANCEF		e or aying	, such as ca	ardiac or re	espiratory arres	τ,	٦	Approximate Interval Between Onset and Death OYears
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):						-		.ogedis
	ב ס	ner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying											
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8760,	icate be physicia s the bur	cal		. d.				_						
Box 6	eath certific attending p I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date	of delive	rv
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۵.	as tha	by Pr	Part II. Other significant conditions of	ontributing to death be	ut not resul	iting in the un	derlying ca	use give	n in Part I.					e cause of death?
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ō	ding Phys h. After this tuneral di	n: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		R/Outpatient 28b. Time of Injury		A Bc. Injury Work	∵ 4 □ Nurs at		Residence Describe how			')
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≥ O	s after all Dirac	Certif	4 Homicide determined	28e. Place of Injubulg	. (Specify)	ne, rarm, stre	eet, ractory	, опісе			City or Town,		or Hurai	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Diractor: After completely tilled in by the tune	edical	29a. Certifier (Check only one) 1X Certifying Ph 2 Medical Exam	ysician: To the best of hiner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred a estigation,	at the time in my opi	e, date and inion, death	place, and occurred a	due to the cau	se(s) and mani and place, an	ner as sta d due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c.	License	number		290	. Date signed	Month, L	Day, Year)
(6		P D M					D29	675		C	ctobe	r 6,	2005
			30. Name and address of person who of Mr. Ralph Bocci				,	3eth	esda	, MD	20814			
Г	Sta Registr	te	Od Date Glad (March David)	32. Jegistra	1 0:					-			· · · · · · ·	

Registrar

			1 - For State Registrar	State of Ma	ryland / Depa		Health and	d Mental Hy	/giene	7 0 0 100	01017	
	* *		Registrar Decedent's Name (First, Middle, Las	it)	06	incate of	Dealii	2. Date of D	Reg. No	2005	3. Time of Death	
	Physici		Gary Frederick	Wilson				Month	Da	y Year 2005	7:45 a M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D			County of Deatl		
			3512 Manorwood Dr	ive		Hyatts			P	rince Ge	orge's	
100	Funeral		5. Social Security Number 6. Se	ox 7. Age XM 2□F	(In yrs. last birthday)	If Under 1 Year Months Day	r If Under 24 F s Hours M	lin. (Month, D	irth lay, Year)	9. Birth Co	nplace (State or Foreign untry)	
	Director		217-44-8261 Usual Residence of Decedent		59 Yrs.			Oct. 2			nington, DC	
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits	
	e-fsl	ctor	Maryland Prince Ge	eorge's	Hyattsvil	.1e					1XYes 2□No	
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Cor	untry?	
	s 23e	rai	3512 Manorwood Dr			20782			U.S.			
	ter de Irer	-une	11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent E Armed Forces?	o 106/	Was Decedent of If Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)	3-	14. Race - American Indian, Black, White, etc.		
99	el', o	by	3 ☐ Widowed 4 ☐ Divorced	1 XI Yes 2 □ N If Yes, Give Year or Dates:	1970	1 ☐ Yes 2 🔼 N	o Specify:			Specify: White		
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23c or 28e-1 show eumetic event, Ite Medical Examiner must be notified at	eted	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occ	upation e during most of	working	16b. K	ind of Business/I		
2	vithin ne. hen *	Completed by Funeral	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	DO NOT use retir	red)	working				
2	Hygie thert	CO	12 17. Father's Name (First, Middle, Last)		Power	Plant E	0	Name (First, Middle			rd/Greenbelt	
ano	be od o	o Be	Fred O. Wilson					Elizabet		,		
Maryland	should be tand Mental I s marked or tumetic ever	To	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stree	1	Rural Route Numb			p Code)	
	D 든 M #		Catherine H. Wils	on: Spouse				, Hyatts				
ore,	of He of He rothe		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Damanal faran Chata	20b. Place of Dispo			Date		ocation - City or T		
Ĕ	Pag ment ent: I ury o		' 4 □ Donation 5 □ Other (Specify		Metropolita	n Cremato	cy Oct	. 7,2005	Ale:	xandria,	Virginia	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signatural Service Licens	see	22	. Name and Add	ress of Facility	Gasch's I	uner	al Home	, P.A.	
_	0 □ = @ O		Marie Mande	120	01373					sville,	MD 20781	
			23d. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line	the death. Do not ent e.	er the mode of dy	ring, such as card	liac or respiratory a	.rrest,		Approximate Interval Between Onset and Death	
	Pnysician / /Medical*		Immediate Cause (Final disease or condition resulting in death)		ryngeal Ca	rcinoma					3 Months	
ě	Examiner		1	Due to (or as a	consequence of):							
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	cuted nd ransit	Examiner	that initiated events	c								
Ö,	ate be executed hysiclan and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):							
8/60	certificate be executed nding physician and use as the burial-transit	Physician/Medical		d								
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Rox	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnan Other (specify)	су		4			
л О	at the de by the a tached	hysi	9 Unknown	9□ Unknown		(
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	entributing to death bu	t not resulting in the ur	nderlying cause g	iven in Part I.	23e. Did	obacco u	se contribute to	he cause of death?	
ğ	w require been sig should b							_ 1 🗆	Yes 2	□No 3□Pro	bably 4X]Unknown	
ပ္ပ	as be	pie						24a. Was		24b. Were auto	opsy findings available	
<u>r</u>	The lav	Completed							ormed?		mpletion of cause of 2 \(\text{No} \)	
Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0		eath Check onl				
0	Phys	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 L Inpatien		t 3 DOA	4 Nursing	Home 5 🕅 Resi 28d. Describe			(y)	
0	ding th. Th. After funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	28c. Inju We M 1	ork? □Yes 2 □ No	200. Describe	iow injur	y occurred		
DIVISION	Attending ir death. ector: After by the fune	Certification;	3 Suicide 6 Could not be determined	286. Place of Injul	eet, factory, office)	28f. Location (Street an	d Number or Run	al Route Number,		
5		Cert	4 Homicide	building, etc.	(Ѕресіту)			City or To	vn, State,)		
	To the Hospitel o within 24 hours aft To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of iner: On the basis of	f my knowledge, death	occurred at the	time, date and pla	ce, and due to the	cause(s)	and manner as s	stated.	
	To the h within 24 To the F complete	Medi	Unay .	and manner stat	ed.			curred at the time,				
,	To To	-	29b. Signature and title of certifier	1 /2			ise number	1027		e signed (Month,	_	
^	10/11/		30 Name and state of	e Oulm	oth (line: 00-) 77		MD 33	JUJ T	Oc	tober (,2005	
1	O IVa		30. Name and address of person who c Andrew Putnam, M.D		ath (Item 23a) (Type, I eservoir Ro		. Washin	gton, DC	2000)7		
4	Sta	te	31. Date filed (Month, Day, Year)					<u> </u>				
	Registr	ar	OCT 0 7 2005	Eleve	s's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#23a. Prt. 1. Per Phys. PGC 10-7-0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 23, Month **Physician** 1:10 P September 2005 Karen Denise Woodfork /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 2517 Southern Avenue, Apt #101 Oxon Hill, Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/19/52 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Days 1 M 2 XF Washington, DC 52 579 -78**-**6038 Director Usual Residence of Decedent permit. Pages 1 and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Exandiant: and be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County No Yes 2 No by Funeral Director Temple Hills, Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20743 2517 Southern Avenue, #101 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yas, Give 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Camp Counselor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Velma D. Spriggs Stanley Melvin Woodfork 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2517 Southern Avenue, #101, Temple Hills, Md 20743 Stanley M. Woodfork / Father 20c. Location - City or Town, State Alexandria, VA 20b. Place of Disposition (Name of Date 20a. Method of Disposition Metropolitan Crematory 9/29/2005 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pope Funeral Homes, P.A. ≥ darr Louisia 5538 Marlboro Pike, Forestville, Md 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS OF THE LIVER **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Des ribe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident s after death the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of offinie 46285 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 10905 Ft. Washington Road, Ft. Washington, MD 20744 Paul Bone, M.D. 31. Date filed (Month, Day, Year) State OCT 0 7 2005 Registrar

State of Maryland / Department of Health and Mental HygieRe[] [] 5Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** Joan Arlene Young 14:12 M /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 🛱 F 62 Yrs. 235-68-0289 Director February 15,1943 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits th and Mental Hygiene. 7 Is markad other than "natural", or Itams 23a or 28a-1 shov traumatic evant, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Washington <u>Hancock</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 242 Pennsylvania Avenue 21750 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked ofth any linjury or other traumatic event, 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl William Shoemaker Virginia M. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia M. Tritapoe/Mother 242 Pennsylvania Avenue Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Union Cemetery 10/15/05 McConnellsbur, PA 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 141 West Main Street mo6528 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (fir as a consequence of): Examiner Lordio ulminary arrest Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed physicien and the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be d 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 THo 24a. Was an 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Diractor: / the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Cartifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00062123 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) Hagerstown mill Street Bolarum 0 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-			For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of Heartificate of De		ental Hygien _{Reg.} (2005	34320	
8	Physici		Decedent's Name (First, Middle, LEC EDGAR LEC		SON		2		d acos	3. Time of Death	
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	- Funeral				e (In yrs. last birthday)	If Under 1 Year II	Under 24 Hrs. 8	B. Date of Birth (Month, Day, Yea	301+,	more_	
	Director	100	246-52-1187	M 2□F	69 Yrs.	Months Days H	lours Min.	(Month, Day, Yea 02/12/1	936 N.	CAROLINA	
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	Ba-f si	Director	MD N/A		BALT	IMORE CIT	Ϋ́			1X Yes 2 □ No	
	3a or 2	i Dir	10e. Street and Number 4918 GREENCRE	ST ROAD		10f. Zip Code 2120	16	10g. C	itizen ol What Cou USA	intry?	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dissal Examinar must be recitifed at	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13. \	Was Decedent of Hispar f Yes, specify Cuban, M		fy Yes or No- can, etc.)	14. Race - Amer Black, White		
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Maryland	2 should be and Mental is marked o	2	JAMES MADISON 19a. Informant's Name/Relationship			g Address (Street and i	MAGNOL I		or Town, State, Zi	io Code)	
	s 1 and 2 if Health a Item 27 is other tra		EARL ANDERSON	/ BROTHE	ER 4214	HOLBROOK	RD, RA	NDALLST	OWN, MD	21133	
nore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Content of the Conten	Removal from State	20b. Place of Dispo- cemetery, crem MD_VETE	sition (Name of natory or other place) RANS CEM. N FOREST	10/27		Location - City or T		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Juneral Service Lice		GARRISOI 22	N FOREST Name and Address of	Facility How		INGS MI ERAL HO		
6	89 E E 9		23a, Part Enter the disease, or co	10 M	SUM 4	600 LIBER	TY HEIG	HTS AVE		MORE, MD	
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	/Medical Examiner		resulting in death)	a. AMI Due to (or as	a consequence of):						
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Вох	that the death cer ed by the attendin detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1⊟Live birth 4⊟Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year	
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	es pe be	þ	Part II. Other significant conditions	contributing to death bi	ut not resulting in the un	iderlying cause given in	Part I.	23e. Did tobacco		he cause of death?	
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o uc	ding Ph h. After th funeral		27. Manner ol Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	28c. Injury at Work?	280	d. Describe how inju		7/	
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Ö	Hospital or 24 hours afte Funeral Dir tely filled in			building, etc				City or Town, State			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medicai	29a. Certifier Certifying P Cert	hysician: To the best of miner: On the basis of and manner sta	examination and/or inv	occurred at the time, da estigation, in my opinior	ate and place, and n, death occurred	due to the cause(s at the time, date an) and manner as s d place, and due to	tated. o the cause(s)	
	To the To the Comp	Ň	29b. Signature and title ol certifier	1 000	MD	29c. License nun		29d. Da	ate signed (Month)	Day, Year)	
	1	}	30. Name and address of person who	Could be sompleted cause of de	eath (Item 23a) (Type F	DS4	TUG	/(709	25	
	5		DR HONA NOVI	ELLO 900	10 Frankli	n Square	- Drive	Baltin	nore 1	40 Z1237	
	Sta	-	31. Date filed (Month, Day, Year)	005 32% Registra	r's Signature	well					

Anderson, Edgar

State of Maryland / Department of Health and Mental Hygiene RegunoU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4:58 AM RNEST AMBROSE OCTOBER 21 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR HOSPITAL BALTIMORE 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs Director 216-36-6297 65 Feb. 15,1940 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23g 412 Lafayette Avenue 21228 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 shoutd be filed w and Mental Hygier Is marked othar th Truck Driver Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Theodore Ambrose, Sr. Virginia Gosnell 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depirtment of Health and Important: If itam 27 Is m any injury or othar traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Bonnie Ambrose - Wife</u> 412 Lafayette Ave.; Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MSBurial 2 Cremation 3 Removal from State 10/24/2005 Sykesville, Maryland Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice See 22. Name and Address of Facility 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc.
736 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Shock Cardingenic house /Medical Due to (or as a consequence of): Examiner CLOSTIC Abdominal Sequentially list conditions, if any, leating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit cremesalized Unknown Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy Ö in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown à signed ! Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen OFRO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Dostructive sleep 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) a Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To tha ! within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) RES DOD Our than M.D. OCTOBER 21 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACHANA PALNITKAR HOUPITAL MARBOR 3001 SOUTH HANDVER BALTIMORE. STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

		•	For State Registrar	State of Ma	aryland /	-	rtment o			F	Reg. No.	05	34322	2
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Baltimore,	permit. Pag Department Important: any injury c QDC9.		21. Signature of Funeral Service Licens Dawn F. McDo	la Omalo	(22	Cremat:	dress of Facili	iety	of Mar	ylano imor	d, Inc	21226	
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	5		led a sa last.	ompleted cause of c	death (Item 23	Ba) (Type,	Print)	JUE	BEL	- AIR	N	いなり	014	
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	n		1. Decedent's Name (First, Middle, La	it)				2. Date of Di	eath Day	Year	3. Time of Dea	th
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Maryland	d 2 sho		19a. Informant's Name/Relationship (•				or Rural Route Numb				
	s 1 and 2 should f Health and Mer Item 27 le marke other traumatic		Cynthia G. Butle 20a. Method of Disposition	c/Daughter	20b. Place of Di	sposition (Name of	thwest 6	th Street	Scattle 20c. Location	City or Town	98107 . State	_
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Baltimore,	# 분분증 .		21. Signature of Funeral Service Licen		Hetto C	22. Name and A	ddress of Facility	Cremation	Baltim	ore, M	<u></u>	_
m	Depa Impo sny iv		Edward A. Gre	porchik		299 F	rederick	Road Balt	imore. N	/ OL MI /D 2123), IIIC.	
2			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	lications that caused	the death. Do not					A	pproximate Iterval Between	
W.	Physician		Immediate Cause (Final disease or condition	a Coroni	consequence of):	y dire	are			0	nsat and Death	٢
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):)	
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9	artifica ing pt e as t	Med	IF FEMALE:									
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	☐Fetal death		23d. Date of delivery Month Day					
P.O.	that the de led by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	me or death	5 Other (specif	у)				ıy Year	
	requires that the reen signed by th hould be detache	by Pt	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying caus	e given in Part I.	23e. Did t	obacco use conti	ibute to the o	cause of death?	,
rds	w requires that s been signed b should be det	ed b	Dilated ischeni	c cardion	yo pathy			11	Yes 2□No	3 🗌 Probabl	y 4 Donkno	WΠ
ဝ၁ဓ	S S S	plet		/				24a. Was	an 24b. V	Vere autopsy	findings availa	ble
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/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				-	Death (Check only o				
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5	ding h. After funer	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year) 28b. Time	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurr	₽d		
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ă	s after s after al Dire	Cert	4 Homicide determined	building, etc.	(Specify)	,		City or To	vn, State)			
	To the Hospital or Attending Physician: within 24 hours after death and 170 the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of iner: On the basis of and manner stat	examination and/or	eath occurred at the investigation, in a	ne time, date and p my opinion, death o	elace, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as state and due to the	d. e cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifler	10 11		29c. Lie	cense number		29d. Date signed	l (Month, Day	, Year)	
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	0,		30. Name and address of person who	ompleted cause of de	ath (Item 23a) (Tyr	e Print)		2				
			Pariel J. Konick	M.D. 13	U Love Po	nt Road	d, #107	Stevensville	(int	1666	>	
24	Sta Registr	1	31. Date filed (Month, Day, Year) OCT 2 5 200!	2. Registrar	's Signature	well .	,					

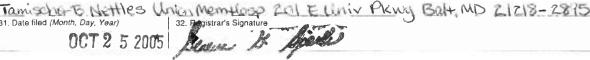
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 05 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Howard Leroy Bell 300 AM () chober 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB 19, 19 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral №** M 2□ F 58 220-42-8417 Yrs. Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Heatth and Mental Hygiene.
ant: If Item 27 Is marked other than "naturel", or Items 23e or 28e-fehovury or other traumatic event, If a Medical Exprised minist be notified at 1 Yes 2 No Director Maryland N/ABaltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1400 Yeager Street 21211 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence W. Bell, Sr. Myrtle Butler P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gene Bell, Sr./brother 5323 S. Main Street Morrisville, MO 65710 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any injury or ot once. Metro Crematory, Inc. 10/21/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of F McDonald Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bowel Obstruction **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Preumania 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 ☐ Yes 2 ¥ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation I Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State

31. Date filed (Month, Day, Year) OCT 2 5 2005 Registrar

Jamusche BNettles, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ATZ438946

October 21, 2005

State of Maryland / Department of Health and Mental Hygiene 34325 For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5.15 D.M QTOBER. Carolyn F. Buckley 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial Hospital 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye NOV 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral**). 1941 Tennessee 63 Director 220-38-7880 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or items 23a or 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location ral', or items 23a or 28a-f show Exercitive must be notified at 1XYes 2 □ No Baltimore Maryland N/ADirector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 707 Belle Terre Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 14. Race · American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specity: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Ballew Paul William Clabough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20030 Gravel Hill Road Georgetown, DE 19947 19a. Informant's Name/Relationship (Type, Print) Barbara J. Blizzard/daughter 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 10/21/05 Baltimore, MD 4 Donation 5 Other (Specify) eny injury ^{22, Name and Address of Facility} Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC ADENO CARCINOMA Physician MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 □ No 3 Probably 4 ₽Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospitel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier fellermana MID OCTUBIER 20,2009 D47/23 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 20, 15 CINIV - PKWY JOSEPH PUTTEN MANNE BALTIMORE 32. Registrar's Signature 31. Date filed (Month: Pay, Year) State Registrar

ORIGINAL

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П	ு Physici	an	Decedent's Name (First, Midd								2. Date of Dea	Day		3. Time of Death
	/Media	cal	Virginio 4a. Fecility Name (If not institution	a Bailey	thos)		4b Ciby 7	Tours or	Location of	of Dooth	Octobe			
	Examir	ier	Heritage Nur		-		40. Oity, 1		ndall			40.	County of Dea Balti	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under Months		If Under:		8. Date of Birt (Month, Day March	h v Year)		tholace (State or Foreign
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	yland Iow		10a. State 10b. County	4	10c. City	y, Town or Lo	cation							10d. Inside City Limits
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	or 28	DIre	10e. Street and Number				10f. Zip					10g. Citiz	zen of What Co	
	s 23a	eral	914 Spangler W		dost Supris II	6 123	Man Danadi		205	=======================================			u. s.	
920	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itams 23a or 28a-1 show ther than "natural", or itams 23a or 28a-1 show ant, it a Modical Examirar must be naiffied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mai 3 🏿 Widowed 4 □ Divorcei	If Yes Give	Ð	5. 13.	was Decede f Yes, speci 1 ☐ Yes 2		Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	
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Jore	Pages 1 nent of H int: If its iry or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		STOREG !	lace of Dispo				10/0	r / c o o r		cation - City or	
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			1- For State of Maryland / Departing State of Maryland / Departing State Registrar Certification Proceedings Procedings Proceedings Procedings ment of Health and Milicate of Death	ental Hygier	ne 2005	34327	
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	Funeral Director		476-46-1035 1□ M 2 ⋈ F 63 Yrs. M Usual Residence of Decedent	onths Days Hours Min.	Month, Day, Ye. April 30	ar) 1942 Mir	place (State or Foreign ntry) INESOTa
	he Marylar 8a-f ehow	Director	Md. Baltimore Luthervil	le			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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3036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ha Medical Exemirar must be notified at	þ	Armed Forces? If Ye 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Mo	Decedent of Hispanic Origin? (Spers, specify Cuban, Mexican, Puerto F Yes 2 X No Specify:	Rican, etc.)	Black, White,	
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Baltimore,	ermit. Pages apertment of aportant: If It ny injury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral/Service, Licensee 22. Na	lley Mem. 10-26-		monium, M	d.
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O. Box 6	the death certifica y the attending pl ached for use as t	Physician/Med		opic pregnancy ner (specify)		23d. Date of delive Month	ory Day Year
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аі жесога	The la ete has page 2	Completed			24a. Was an autopsy performed?	death	osy findings available inpletion of cause of
sion or vital	ding Phys n. After this funeral di	ation: To Be	2 Accident			6 □Other (Specify ury occurred)
DIVISION	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - Al home, farm, street, f building, etc. (Specify)		City or Town, Sta		
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investige and manner stated.	gation, in my opinion, death occurred 29c. License number	d at the time, date a	s) and manner as st nd place, and due to rate signed (Month, L	the cause(s)
	6		Alan Kennel mo	D52747		10-24-	OS
	/ ()	te		Charles St Ba	elt Ma	21204	
	Registr		31. Date filed (Month, Day, Year) OCT 2 5 2005	P			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For Stete Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Daniel Burke October 20, 2005 8:05 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore 5. Social Security Number 8. Date of Birth Month, Day, Year) May 23, 1922 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

North Days Hours Min. **Funeral** 6. Sex 9. Birthplace (State or Foreign 1□**X**M 2□F 183-14-5334 83 Yrs. Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Freeland Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21005 Kenney Mill Road 21053 U.S.A. or Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ N If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Personel Manager Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Burke Helen McNealv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 is any injury or other trains Robert B. Eickhoff-nephew 843 High Plain Dr., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dur Mother of Sorrows 10/24/05 Greenfield. PA `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1050 York Rd., Towson, MD 21204 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à End 3/35 5 densolie 1 Yes 2 No 3 Probably 4 Hinknown Be Completed COENSIF 4/15 SE 12/410, Jaron 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No performed' certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a' Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and titl of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUMMD21093 31. Date filed (Month, Day, Year)
OCT 2 5 2005 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

OCTOBER

Box 68760.

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Vital

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygion 15 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 **Physician** October 24, Paula M. Bengel 12:38 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 □ M 2 1 F 219-32-0539 96 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral, or Items 23a or 28a-f ehow Examiner must be nutified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 17 Chiara Court USA "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Bakery Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be fill and Mental H Be Placht Johann Gamnitzer Rosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau 17 Chiara Court Towson, Maryland 21204 Johanna R. Bengel (daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hillton Svc. Corp. 10/25/2005 Towson, Maryland 4 Denation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral Service Licensee Stephen Coster 1050 York Rd., Towson, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death E HE GroV250/42 Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consecu Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physiclan/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. 0 r sig cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27 Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 29c. Lieense number 29d. Date signed (Month, Day, Year) 29b. Signature 10 24. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (90172 5 2005 2. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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		1	For State Registrar	State of Maryland		nt of Health and M ate of Death	lental Hygie 1 Reg.		34330
*	Physicia	_	Decedent's Name (First, Middle, Last	, ,	Pala	1	A .	Day Year	3. Time of Death
	/Medic	al -	YVE 4a. Facility Name (If not institution, give		1 4b. Cit	y, Town, # Location of Death	OCTOBER	4c. County of Death	1:40 PM
	Examin	er.	// / AA	MORIAL		BATIMOR	E		
	Funeral Director		218.80.7730	ex 7. Age (In prs. last	Yrs. If Und Month	ler 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth	59 MA	nplace (State or Foreign
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	ownor Location				10d. Inside City Limits
	Ba-fal	Director	MD		DATIL	MORE			1 MZYes 2 ☐ No
	th with the 23a or 2 and be no	al Dire	10e. Street and Number 1827 E. 33	RR STREET	T 10f. 2	Zip Code	10g.	U.S.A	1.
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23e or 28e-f ahow amy injury or other traumatic avent, I're Medical Exprinal Caul buildlisd at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
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Aary	12 should and Men is marke raumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ess (Street and Number or Rur	al Route Number, Ci	ty or Town, State, Z	Tip Code)
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Baltimore,	Pages nent of int: if it		1 ☐ Burial 2 🗹 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	IRAMOVALITOM STATE 1// .	N MOVN (REMATORY 10.	25.05 BA	CTIMOKE, N	LARYLAND
3alti	permit. Pag Depertment Importent: I any injury c		21. Signature of Funeral Service Licer	nsee li	22. Name	and Address of Pacility VA	200,000,000,000	4.4	THE RESERVE OF THE PARTY OF THE
	40 5 e Q		23a. Part1. Enter the disease, or com	plications that caused the death.	Do not enter the m	YORK KOAD node of dying, such as cardiac		DRE I MARY	Approximate
J	Physician		shock, or heart failure. List only Immediate Cause (Finaf disease or condition	one cause on each line.		NOMA			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):		^		C DUAZ
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	To the Hospitei or Attending Physicien: The law within 24 hours after death. To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:		hysicien: To the best of my knowle miner: On the basis of examination and manner stated.					
	To the within 2 To the comple	Me	29b. Signature and title of certifier	· · · ·		29c. License number		Date signed (Monti	n, Day, Year)
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	1		30. Name and address of person who TRYA SINGH I	completed cause of death (ftem 2:	3a) (Type, Print)	TV ADVINAN	RAITIM	DOE MI	21918
A 18	Sta	ate	31. Date fifed (Month, Day, Year)	32. Registrar's Signatur	ON VERSI	TY ARKWAY	ואו) שרכו	UND THE	2 41910
	Regist	rar	OCT 2 5 2	1005 paren 15	A CONTRACT				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 State Registrar Amend Item #19b Per INF G849 411 104 1990 5 Compath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Oliver Bowes Bond 10 02:48pM 19 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08-17-1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 → M 2 □ F 81 218-38-3313 New Zealand Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10000 Brunswick Ave #319 20910 New Zealand 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 1 ☐ Yes 2 TNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cardiologist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil George Bond Stella Violet Hall 19a. Informant's Name/Relationship (Type, Print) 19by Office documents and demonstrate Royle Number, City of Town, State Secondary College Waters de Russer Code)
19515 Frederick Rd. 172 Germantown Mb 20876 Stephanie J. Lamm/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 10-25-2005 4 □Donation 5 □ Other (Specify) Beltsville MD 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 21. Signature of Funeral Service Licensee ma1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Intarction Vocardia resulting in death) Due to (or as a consequence of) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Tyes 2 No 2∑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 ∰Naturaf 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D28426 10-20-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Galen Hallick 1500 Forest Glen Rd. Silver Spring MD 20910

Registrar DHMH 17 Rev 1/2001

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permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if item 27 is marked other tt any injury or other treumatic event. In QDGB.

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

filed within 72 hours after deeth with the Maryland

altimore, Maryland 21215-0036

32. Registrar's Signature

			1- State of Maryland / Depart Certification Certification Certification Certification The state of Maryland / Depart Certification Certificat	tment of Health and Me ficate of Death	ental Hygler Reg. i	2000	34332
	Physici	an	1. Decedent's Name (First, Middle, Last)	_	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir	cal	Clara Kiah Booker 4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death		3, 2005 4c. County of Death	10:05P ^M
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	Funeral Director		213-16-7994 1 M 2XXF 91 Yrs. N	If Under 1 Year If Under 24 Hrs. Anonths Days Hours Min.	d. Date of Birth (Month, Day) Yea arch 29,	1914 Mary	place (State or Foreign http: / I and
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	ath with th	ral Dire	300 East Seminary Avenue	10f. Zip Code 21093		Citizen of What Coul USA	
920	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28e-f show way injury or other treumatic event. The Medical Examinar must be notified at ODGS.	Completed by Funeral Director	A CONTRACTOR OF MARKET A CONTRACTOR A CONTRA	s Decedent of Hispanic Origin? (Species, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	
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Baltimore,	thent of the tent: If ite		20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State A Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremate Bethel AME	Ch. Cem. 10-26-	05 Can	mbridge Ma	ıryland
Bal	permit. Departr Importe eny inju		27 Signature of Funeral Service Licensee 22. N	lame and Address of Facility Mitche 6500 York l		ela funeral i nore, Marylai	
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ords	w require been sig should b	ted t			1 🗆 Yes	2 PNo 3 Prob	ably 4 Unknown
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Vital	Phyeician: The this certificate har all director, page	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (
of	> .∞ 0	ت: To	27. Manner Death 28a. Date of Injury 28b. Time of	28c. Injury at 28	5 Residence d. Describe how in	6 ☐Other (Specifically occurred)	y)
ion	Attending F r death. ector: After by the funer.	atlo	2 Accident	Work? M 1 Tes 2 No			
Division	tel or Atters a ster de el Directo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office 28	f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death oc control of the basis of examination and/or investigation and manager stated.	ccurred at the time, date and place, antigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as si and place, and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and the of Certifier	29c. License number		Date signed (Month,	Day, Year)
	,		30, Name and address of person who completed cause of death (Item 23a) (Type Prin	W) D24/2/	10	125/05	
	5		BRUCE ROSENBERG //21	WEST. PD	Tows	son me	D
•	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 5 2005	E)		212	204

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 34333 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** ALINER, BRAD 7. ZOAM 244 2005 OCT /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BRIGHTWOOD LUTHERVILLE BALTIMORE 8. Date of Birth (Month, Day, 09/02/ If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Days Hours Months MARYLAND 1 M 2 7 F 67 212-38-4241 Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Manylend neat of Health and Mental Hyglene. and of Health and Mental Hyglene. and if Item 27 is marked other than "netural", or items 23s or 28s-f show ant: If Item 27 is marked other than "netural by notified at ury or other traumatic event, the Medical Exprince must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director BALTIMORE LUTHERVILLE 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 108 CASTLETOWN RD. UNIT 302 21093 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) LIBRARIAN LIBRARIAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be MARGERY STARR W. RONALD ROCHE SR. 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) E. PHILIP BRADY JR. (HUSB.) 108 CASTLETOWN RD. UNIT 302 LUTHERVILLE, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department in important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) DULANY VALLEY MEM. 10/28/2005 TIMONIUM, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) VON HIPPEL LINDAU DISEASE Examiner Physician/Medical Examiner MONTHS INSUFFICIENCY ADRENAL or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) ate has been signed by the a pege 2 should be datached Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown Be Completed by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28e. Date of Injury (Month, Dey Year) Natural 5 Pending s efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) completaly filled in by 4 ☐ Homicide Hospital within 24 hours of To the Funeral I 29a. Certifier TECertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. (Check only one) 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature end title of certifier D0053150 007 245 2005 epte MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SUITE 110 9650 SANTIAGO ROAD. COUPTA COLUNBIA 21045

DHMH 16 Rev 6/95

State Registrar Sh ALUNY A

32 Registrar's Signature

		-	State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N Certificate of Death		giene Reg. No.	005	34334
1	Physicia	an I	1. Decedent's Name (First, Middle, Last)	2. Date of De Month		Year	3. Time of Death
	/Medic	al -	4a. Cacility Name (If not institution, give street and number). 4b. City, Town, or Location of Death	10	2/ 4c. 0	200	
	Examin	er	BALTIMORE WASHINGTON MEDICAL CENTR Glen BURN	DIE	1	NNE	-HRundel
	Funeral Director		5. Social Security Number 6. Sex 1XD M 2 F 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 19. Age (In yrs. las	8. Date of Bir (Month, Da 9-24-	y, Year)	9. Bir	thplace (State or Foreign buntry) MD
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryla -f sho	ţō	MD Anne Arundel Millersville				1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citiz	en of What Co	ountry?
	a 23a		8409 Elvaton Road 21108-1215 11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Sp	posity Vos or No		4. Race - Ame	arican Indian
38	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 ia marked other then "natural", or Itama 23a or 28a-f show any injury or other traumatic evant, the Medical Examinating the multiplical anone.	by Funeral	11. Marital Status 1 Never Married	Rican, etc.)		Black, Whi	e, etc.
2-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kin	d of Business	/Industry
aryland 2121	iene. r than	omp	Elementary/Secondary (0-12) College (1-4or5+) 12 Truck Driver		Te	amster	s
pu	e filed al Hyg d othal	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name Description:			Sumame)	
ıyla	d Ment marked matic	ပို	Fritz Bock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	a Ruehl		Town State	Zip Code)
Z	nd 2 sl alth an 27 ia r ir traur		Charlett Bock / Wife 8409 Elvaton Road; Mi				
altimore,	es 1 a of Hea if itam or otha		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State	Date	20c. Loc	ation - City or	Town, State
Ē	it. Pag rtment rtant: njury c		`4 □Donation 5 □Other (Specify) Glen Haven Memorial Pk 10-			n Burn	
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ĺ			23a. Part 1. Byter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac shock, or near failure. List only one cause of each line.				Approximate Interval Between Onset and Death
H	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. A CUMONICE a. A CUMONICE The CUMONICE T				[most
	Examiner		ACID Penel Fallen				/week
7	pi ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	execute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dicai E	d				
9		0	IF FEMALE: 23c. If yes, outcome of pregnancy		0.	2d Date of de	livani
.O. Box	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as l	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		2.	3d. Date of de Month	Day Year
٥.	res that I	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco us	se contribute t	the cause of death?
ords	w require been sig should b	ted t	Wilmonay F. Bross		1]No 3□P	
Vital Records,		Completed		24a. Was auto perfe 1 Yes		24b. Were a prior to death?	utopsy findings available completion of cause of
	ding Physician: Th n. After this certificate funeral director, pag	o Be	25. Was case referred to medical syxaminer? 1 Yes 2 No Hospital: 1 Pinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	th (Check only ome 5 Resi		Other (Soc	ocifu)
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Division	of or Attendated after death Director:	ertifi	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide		wn, State)	rivaniber or A	urai Houte Number,
	To the Hospital or At within 24 hours after of To tha Funaral Direct completely filled in by	edical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 12 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the rred at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)
)	To the within	M	29b. Signature and more certifiers ELECTION D2-0094		10	signed (Mon	65
	6		30. Name and address of person who completed cau h (Item 23a) (Type, Print) Elliot Gorbachy and, 1411 Medisin Park	Drive.	Clan	Burn	e, bed, 21061
	Sta		31. Date filed (Month, Day, Year)	(_		1 19 3 4
H	Regist	ar	OCT 2 5 2005				

				For State Registrar	State of Maryla	ind / Depa <i>Cer</i> t	rtment of l	Health and M Death	Mental Hyg	ien 2005	34335
-		Physici /Medic		1. Decedent's Name (First, Middle, Last)		BARBOUR	2		2. Date of Deat Month		3. Time of Death
		Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of Dea	
		Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
		Director		Usual Residence of Decedent 10a. State 10b. County		City, Town or Loc	otion		APRIL 16	1919	MD.
		e Maryla la-f sho	ctor	A .	WARD	ony, Town of Loc		umBiA			10d. Inside City Limits
		3a or 28	i Director	10e. Street and Number 6117 SEABK	ins DR		10f. Zip Code	21044	11	Og. Citizen of What Co	,
	10	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or items 23a or 28a-f show that the Medical Examinar must be rodified at	Funerai		12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	U.S. 13. W		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
	-0036	hours a	by	3 ₩idowed 4 Divorced 15. Decedent's Educ	If Yes, Give Year or Dates:		Yes 22 No			Specify: iu	
	21215-0036	within 72 ane. then "ne	Completed	(Specify only highest grade	College (1-4or 5+)	(Give k	ind of work done NOT use retire	during most of work d)	ang	16b. Kind of Business MARTIN	•
		should be filed with itd Mantal Hygiene marked other the matic event, Ins.	Be Co	17. Father's Name (First, Middle, Last)	2/2		DKIVER	18. Mother's Nam	e (First, Middle, A	Maiden Sumame)	CORP
	Maryland	d 2 should be f th and Mantal I 7 is marked of traumatic eve	^L	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street		Ret it	h Rews	Zip Code)
Z		1 and 1 and		MARGARET Hill 20a. Method of Disposition	20b.		SCABRIAS	DR. Col	UMBIA		44
28pm	Baltimore,	Pag nent int:		1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cemetery, crema ACOLANS a	tory or other place	(B) 10/2	5/05	Roselale	MIS
N	Ball	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lice	tella	22.1 H 6	Name and Addre	SS of Facility STE	BAlto.M	D 21774	CHTD.
(₁ _		Physician		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final	A /	ath. Do not enter	the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
2005	E.A.	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conse		ell				Days
39	×	pe tis	liner	Sequentially list conditions, the last sequentially list conditions, the last sequential	Una fo (or as a conse	squanca of):					
Da	50,00	cate be executed physician and the burial-transit	I Examiner	that initiated events cresulting in death) Last	Due to (or as a conse	equence of):					
Jak	68760,		ledical	d							
la (.O. Box	Physician: The law requires that the death certificing this certificete has been signed by the attending raid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal déath 3 □E	ctopic pregnancy Other (specify)	, as	-	23d. Date of del Month	ivery Day Year
Veronia	α.	res that II signed by I be detac	by	Part II. Other significant conditions con	tributing to death but not re		erlying cause giv	en in Part I.		acco use contribute to	
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rbow,	of Vi	Phyaician; this certific al director,	To Be	examiner? 1 \(\text{Yes} 285 \text{No} \)		☐ ER/Outpatient	3□ DOA Oth	er: 4 ☐ Nursing Ho		nce 6 Other (Spec	city) Hospice
Bar	ion	gr eft.	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	y at k? Yes 2 □ No	28d. Describe how	w injury occurred	
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		To the Hospital or Attendi within 24 hours aftar daath. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	nowledge death nation and/or inves	edulted at the tin stigation, in my o	na, date and place, pinion, death occurr	and due to the car ed at the time, da	ass(s) and mariner as te and place, and due	stated. to the cause(s)
		To the within To the complete	Me	29b. Signature and title of certifier			29c. Licensi		į.	d. Date signed (Month	
		m		30. Name and address of person who con	mpleted cause of death (Ite	em 23a) (Type, Pr	1	61199	6	Oct, 22.	2005
	4			Jason Black 6	5607 Nor	The Char	les ST	Tous	in MD	2120	1
		Sta Registr		31. Date filed (Morth, Page Year) 2005	2. Registrar's Sign	Louis	San San San San San San San San San San				

Davon T. Butler Unknown 05-07060 crn

	-	•	lack indelible ink. Ensure A		
1 - For State Registrar		State of Maryland	d / Department of Health and N	Mental Hygiene 005	34336
Registrar			Certificate of Death	Reg. No.	
Decedent's Name (Fi	rst, Middle, Last)			2. Date of Death	3. Time of Death
DAVO	ON T.	BUTLER		October 17 2005	10.32 P

Physic /Med Exam

Funera Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any Injury or other traumatic event, The Medical Examinating to Intelliged at ORG.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit. To the Hoepital or Attending Physician: The law requires thet the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Registrar		Certific	cate of L	eath	Re	g. No.		
Decedent's Name (First, Middle, Last DAVON T	BUTLER				2. Date of Death Month	Day Yea		
DAVON I			O. T	1	October	17 200	5 10:32 P	
4a. Facility Name (If not institution, give	street and number)	4b.		Location of Death	1	4c. County of De		
Sinai Hospital 5. Social Security Number 6. Se	x 7. Age (In yrs. la.	et hirthday. If U	Balti Inder 1 Year	More If Under 24 Hrs.	8. Date of Birth	N/		
,	DM 2□F 19		nths Days	Hours Min.	JULY 5		irthplace (State or Fore Country) MD	
Usual Residence of Decedent					13011),	1900	, AID	
10a. State 10b. County	10c. City,	Town or Location	1				10d. Inside City Lim	
MD	В	ALTIMORI	E				1∭ Yes 2 □	
10e. Street and Number		10	f. Zip Code		10	g. Citizen of What (Country?	
MD 10e. Street and Number 729 CAREY STREET 11. Marital Status 1 ★ Never Married 2 ☐ Married				217		USA		
11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 📉 No	i. 13. Was I	specify Cubar	panic Origin? (S , Mexican, Puerti	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Y	es 2X No	Specify:		Specify:	BLACK	
15. Decedent's Edu		16a. Decedent's	Usual Occupa	tion	110	6b. Kind of Busines		
15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind) life. DO N	or work done d OT use retired)	uring most of wor	king		-	
8		FAST 1	FOOD TE	CHNICIAN		McDONALD	'S	
17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	aiden Sumame)	-	
DANIEL BUTLER				ROSE CA				
19a. Informant's Name/Relationship (T) ROSE CARLTON/MOTHE				nd Number or Ru TON AVEN	ral Route Number, (City or Town, State	Zip Code) 21217	
		OZ/ IN .			-			
20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ F	Removal from State	metery, crematory	or other place)		C. Location - City o		
4 Donation 5 Other (Specify) MT ZION CEMETERY 10-27-05 BALTIMORE, 21. Signetoxe of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SON								
21. Signature of Funeral Service Licens	** — — — — — — — — — — — — — — — — — —			URENS ST		ORE, MD	21217	
23a. Page Enter the disease, or complete	in forcon							
sh , or heart failure. List only o	ne cause on each line.		mood of dying	. sacri as cardiac	or respiratory arres	·t.	Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a conseque c. Due to (or as a conseque	, 	_					
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions con	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 Ector	□Ectopic pregnancy 23d. Date of delivery Month Day					
Part II. Other significant conditions con	ntributing to death but not result	ting in the underly	ing cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?	
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					autopsy	d? days?	autopsy findings availa completion of cause	
25. Was case referred to medical				26. Place of Deat	th (Check only one)	No 1X Ye	s 2 No	
examiner? 1X Yes 2 □ No	Hospital: 1 Inpatient 2 El	R/Outpatient 3[DOA Othe		ome 5 Residence	ce 6 □Other (Sn	ecify)	
27. Manner of Death		28b. Time of Injury	28c. Injury Work		28d. Describe how		subject was	
1 Natural 5 Pending 2 Accident investigation	10/17/05	11:09 PM	1 🗆 Y	es 2 No	5K	ot	V - 4	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fa			28f. Location (Stre. City or Town	et and Number or F State) 350	Rural Route Number.	
'\		street			HUE. Ba	Himore m	/)	
(Check brilly 2x Medical Exami	sician: To the best of my knowl ner: On the bass of examinatio	ledge, death occu on and/or investig	arred at the time	, date and place, nion, death occur	and due to the cau	se(s) and manner a and place, and di	as stated.	
one) 29b. Signature and title of certifier	and manner stated.	•						
255. Signature and title of certifier	1.11.		29c. License OCM			. Date signed (Mor		
Yamer Jouth	ay, nu					tober 18	·	
30. Name and address of person who co	empleted cause of death (Item 2	23a) (Type, Print)	111 Pe	n Stree	t Baltim	ore, Mary	land 21201	
31. Date filed (Month, Day, Year)	32. Pygistrar's Signatus	re .						
	105 Rever A	K door	E.					
4612520	The state of	Japan						

Registrar

			1- State of Maryland / Department of Health and Me Certificate of Death		
	Physicia	(F)	Decedent's Name (First, Middle, Last)	Reg. N 2. Date of Death Alonth / D	3. Time of Death
	Physici /Medio	al	EVELIN OLEDA CHAVIS	CHOBER.	21, 2005 (4 p M
A. S. S. S. S. S. S. S. S. S. S. S. S. S.	Examin	er	4a. Facility Name (If not institution, give street and number) 1/ Ki R. Y. A. M. C. C. C. T. A. D. City, Town, or Location of Death Ab. City, Town, or Location of Death Ab. City, Town, or Location of Death Ab. City, Town, or Location of Death Ab. City, Town, or Location of Death Ab. City, Town, or Location of Death Ab. City, Town, or Location of Death	Ly "	N/A
	- Funeral Director		5. Social Security Number 231-30-3853 6. Sex 1 M XXF 7. Age (In yrs. last birthday) 77 Yrs. 1 Under Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth Month, Day, Yea 11/08/1	9. Birthplace (State or Foreign Country)
	ט		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1170071	
	Maryla -f ehov	tor	147		10d. Inside City Limits 12 Yes 2 No
	or 28a	Director	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Country?
	ns 23e	Funerai	2 2 3 4 6 CALVERTON HEIGHTS AVE. 2 1 2 1 6	ity Yes or No-	USA 14. Race - American Indian,
900	772 hours after death with the Maryland "natural", or items 23a or 28a-f show calcal Expediter mast be rediffed at	þ	If Yes, Give 1 Yes 2 XNo Specify:	can, etc.)	Black, White, etc. Specify: BLACK
21215-0036	within ene. then	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOD SERVICE WORKER	WE	Kind of Business/Industry CSTERN ELECTRIC ORPORATION
nd	be filed ntal Hygi od other event, I	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (I		
Maryland	should I nd Meni marke umatic	ပ္	ROBERT LEE MELVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F		
	alth a 27 is		BRENDA J. CHAVIS / DAUGHTER 1865 FOXWORTH CIR		TCHELLVILLE, MD
Baltimore,	m 0 - L		20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of KING MEM. PARK 10 / 27		Location - City or Town, State RANDALLSTOWN, MD
Balt	permit. Page Department of important: if eny injury or once.		Wan 4600 LIBERTY HEIG	GHTS AVE	NERAL HOME 21207 C, BALTIMORE, MD
П	* *		23a. Part. Phier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respect, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease of condition resulting in death) a. Coro No. Vos Curo Due to (or as a consequence of):	ideas	-
-	Examiner	e.	Sequentially list conditions, if any, leading to immediate b. Chromic Rough Facilities Due to (or as a consequence of):		
V	outed nd ransit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b.		
.09	ficate be executed physician and is the burial-transit				
68760,		ledicai	d		
.O. Box	that the death certiff led by the attending detached for use as	Physician/M	4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	sigr d be	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,		Completed		24a. Was an autopsy performed?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		
		. To	Impatient 2 tereprodupatient 3 DOA 4 Nursing Home	5 Residence	6 ☐Other (Specify) jury occurred
Division	Attending r death. ector: After by the funer	catio	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation 3 Suicide 6 Could not be		
Divi	ol or Attentation after deal	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ft. Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospitel or Al within 24 hours after of To the Funerel Direct completely filled in by	edicai C		d due to the cause(at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	Ž	29b. Signature and title of certifier 29c. License number	29d. D	Date signed (Month, Day, Year)
,	,		30. Name/and Press of person who completed cause of gleath (Item 23a) (Type, Print)		Ulalius
	4		Michael Jen M.D. Go Mary and Gener	ral H	OSpital
	Sta Regist				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 20b, c per fh 8848 10-25-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month. Year Coleman 12:45A M elia October 2005 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bay View
5. Social Security Number 6. Sex Care Cente Baltimore Ma If Under 1 Year | If Under 24 Hrs. | hmore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours Min. 1 ☐ M 2 🖼 20 7108 South Carolina March 11,19.23 Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. ALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 51, 2/2/3 324 EAST DERAL 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND FOSTER! 17. Father's Name (First, Middle, Last) 18 Mother's Name /First Middle Maiden Sumame! RUFUS FLOSSIE 19a. Informant's Name/Relationship (Type, Print) DAMShifter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MD. 21206 20a. Method of Disposition Baltimore, Maryland 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 10-28-05 22. Name and Address of Facility PHILLY A. Weatherford Funeral Serices 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Jue to (as a consequence of) nemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Disease that initiated events resulting in death) Last 23d. Date of delivery Day o use contribute to the cause of death? 2 **N**O 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 ☐Other (Specify)

Physician /Medical **Examiner**

poce

Physician

/Medical

Examiner

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10a State

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Funeral

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Completed

Be

2

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other treumatic avent. The Me

Baltimore, Maryland 21215-0036

and I-transif

Division of Vital Records, P.O. Box 68760,

kaminer

hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □Ectopic				23d. Date of delivery Month Day Yea	
d by P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlyin	g cause	given in Part I.	23e. Did tobacc	co use contribute to the cause of deal 2 No 3 Probably 4 Unk	
Complete						24a. Was an autopsy performed		
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Othor	th (Check only one) ome 5 Residence	6 ☐Other (Specify)	
	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1	njury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, factify)	tory, offi	ice	28f. Location (Street City or Town, St	and Number or Rural Route Number ate)	
edical (
Me	29b. Signature and title of certifier	Cartte	mo	29c. Lic	ense number 85763		Date signed (Month, Day, Year) Wer 20, 2005	

of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Baltimore Md 21224

			For State Registrar	State of Maryla		tment of He			iene 005	34339
	Physicia	an	Decedent's Name (First, Middle, Last)	01.1	1			2. Date of Death Month	h Day Year	3. Time of Death
	/Medic Examin Funeral Director		4a Facility Name (If not institution, give s 5. Social Security Number 6. Sex 213-60-1703	Hospital	enter : last birthday)	4b. City, Town, or If Under 1 Year Months Days	stertow	Date of Birth (Month, Day, 1°ED . 05,	4c. County of Deat 4c. Per 9. Birt Year) 1951 Bal	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Queen An		ity. Town or Loca					10d. Inside City Limits 1 ☐ Yes 2ÂNo
	with the	Director	10e. Street and Number 312 Shawn Road			10f. Zip Code	1617	10	og. Citizen of What Co	•
980	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or items 23e or 28e-f show event, the Medical Exertil at traditional at	by Funeral		2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			spanic Origin? (Speci , Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White	rican Indian,
Maryland 21215-0036	a within 72 ho jiene. r than "natur ine Medicel.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give ki	nt's Usual Occupa nd of work done di NOT use retired) Stant Su	uring most of working	1	16b. Kind of Business/	
land		To Be C	17. Father's Name (First, Middle, Last) Eugene Russell Char	mberlin,Sr.			18. Mother's Name (
	nd 2 sho aith and 27 is m r treum		19a. Informant's Name/Relationship (Ty.) Anita Lyrm (nee Edg			Address (Street a awn Road	nd Number or Rural I Centre	Route Number. 7ille,Ma	City or Town, State, 2 aryland 2	Tip Code) 1617
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State EV	Place of Disposit cemetery, crema ans Fune	ion (Name of tory or other place ral Chape	el Oct.25		Poc. Location - City or Forest Hi	Town, State 11 , Maryland
Balt	permil. Page Department o Important: If any injury or once.		21. Signature of Funeral Service License	um .	Pea 232	vame and Address Ceful Al 5 York Re	of Facility ternatives oad Timor	Funera	al&Cremation	on Ctr.,P.A. 1093
8760,	Physician bulletian and physician street per physician and physician and physician street p	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	arhy equence of): demo	Hmia	, such as cardiac or i	espiratory arre	St,	Approximate Interval Between Onset and Death Sudde
.O. Box 68	it the death certificate be executed by the attending physician and tached for use as the burial-transil	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fei 4 Pregnant at time of 9 Unknown	tal death 3 □E	ctopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Δ.	luires Ihat I n signed by uld be deta	by	Part II. Other significant conditions cor	tributing to death but not re	sulting in the und	erlying cause give	n in Part I.		acco use contribute to	the cause of death?
al Records,	: The law requires that cate has been signed b , page 2 should be deta	Completed						24a. Was an autopsy perform	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2	ER/Outpatient	3 DOA Other	26. Place of Death (nce 6 ☐Other (Spec	
ion of	_ = =	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28		w injury occurred	ny)
Division	in Pitte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stree	t, factory, office	28	f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	one) 2 Medicel Exemil	ician: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death on nation and/or inves	stigation, in my opi	nion, death occurred	at the time, da	te and place, and due	to the cause(s)
	To Your		29b. Signature and title of certifier	, /		29c. License	number	29	d. Date signed (Month	n, Day, Year)
	1		30. Name and address of person who co	mpleted cause of death (Ite	om 23a) (Type, Pr	104 / (a int)	2/		5.24.05	
	Sta	to	35 40 Center //e 31. Date filed (Month, Day, Year)	Rel Central 32 Registrar's Sign	culle 1	ud 21	41+			
	Registr		OCT 2 5 200	5 Reserve	y. Good	Les of				

			For State Registrar	State of Maryland		rtment of H tificate of L			giene 005	34340
	Division		1. Decedent's Name (First, Middle, Last)	n				2. Date of Dea	th Day Year	3. Time of Death
	Physicia /Medic		SHARON MEC	ISSA COL	LEMI	CINE		Oct	24 200	5 830 AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)	10	4b. City, Town, or	Location of Deatl	n	4c. County of Dea	ath
			5. Social Security Number 6. Sex	17. Age (In yrs. Ia	استالی	If Under 1 Year	If Under 24 Hrs.	R Data of Birth	Har	or .
	Funeral Director			M 2 F / Age (III yrs. Ia	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	rthplace (State or Foreign ountry)
			Usual Residence of Decedent		1			1 0	- 1964 YE	NNSYLVANIA
	ylanc how	. [10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Ba-fs	cto	MO HARFORN) t	SEL	AIR				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	0		10f. Zip Code		1	10g. Citizen of What C	ountry?
	ath w	ra	588 HENDERSON	, KO		210,			USA	
	ter de	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No		as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
38	within 72 hours after death with the Maryland ene. than "natural", or tems 23a or 28a-f show fre M. Jic. Exe. it or front be motified.	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐ No	Specify:		Specify:	WITE
ğ	2 hou	Completed	15. Decedent's Edu	ation	16a. Deced	ent's Usual Occupa	ation	<i>(:</i>	16b. Kind of Business	s/Industry
21215-0036	thin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. D	ind of work done of O NOT use retired	unng most of wor)	King		
	ed wii	5	12		1	OMEMAK			KESIDE	NCE
<u>n</u>	be fill d oth	Be	17. Father's Name (First, Middle, Last)	_					Maiden Surname)	- V-
3	d Mer narke	²	19a. Informant's Name/Relationship (Ty	ARNEY	105 14-10-	Add (C44		MARIE	SEKRET	
Maryland	d 2 sl th and 7 ls r traur		D-00 - C	/ SISTER	L CC	. 1			r, City or Town, State,	MD 21014
	1 an Heal Iem 2		DEBBIE FLOWER 20a. Method of Disposition	20b. Pla	ace of Dispos	HENDE		Date	20c. Location - City of	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Extractive forther recitified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		atory`or other place	1001	DRER !	FOREST HE	1) mD
ቛ	artme ortar injur		21. Signature of Fyrieral Service License		22.	RAL CHAFE Name and Addres		-1000	NERAL CI	JOEC PA-
ă	permi Depar Impor any ir		16/ to 15	1 Ch	-	CAIR	FOREST		MD 210	
			23a. Part1 Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death.			g, such as cardiad	or respiratory arr		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Pancrati		aulth				Onget and Death
	/Medical		resulting in death)	Due to (or as a conseque		9 - 10 - 1				3,,,,,,
	Examiner		Sequentially list conditions,							
	ed isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
_	xecut and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
38760,	icate be executed physician and s the burial-transit	dicai								
_	tificating phy g phy as the	Ψ								
Вох	aw requires that the death certifications is been signed by the attending I should be detached for use as	Physician/M	23b. was decedent pregnant	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal o		Ectopic pregnancy			23d. Date of de	
Э. Е	e dea he at	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown		Other (specify)			Month	Day Year
P.O.	res that the de signed by the a i be detached f		Part II. Other significant conditions cor	tributing to death but not resul	ting in the up	dorhina eques ave	on in Part I	23a Did to	bacco use contribute t	o the cause of death?
g,	signe	d by	Tary ii, said ogimisan saidinasoo	induing to death out not resul	ang in the an	derrying cause give	silii Cati.	1 🗆 Y		robably 4 Unknown
Ö	w require been sign should b	Completed						24a. Was a		
Re	0 4 0	mo						autops	sy prior to death?	
ā	ician: Th certificate rector, pag	e Co	25. Was case referred to medical				25 Plane of Dec	1 ☐ Yes ath (Check only or		s 2 No
5	S =	0 8	examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Othe	193		ence 6 Other (Spe	acifu)
jo	cling Phy h. After thi uneral o	n: T	27. Manner of Death		28b. Time of Injury	28c. Injury Work			ow injury occurred	soliy)
Ö	Attencing r death.	atio	117 Natural 5 Pending investigation	(Mornin, Day 7 dar)	injury		res 2□No			
Division of Vital Records,	or Attendenter de Directorin by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	lural Route Number,
	To the Hos pital or Attencii within 24 hours after death. To the Funeral Director: A completely filled in by the 'u		00-0-00				<u> </u>			
	Host 24 hos Fure stely fi	Medical	29a. Certifier Certifying Physical Check only 2 Medicel Exeminates	sician: To the best of my know ner: On the basis of examination and manner stated.	on and/or inv	estigation in my or	pinion death occu	rred at the time d	ate and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and maining stated.		29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
}	- s + ō		· DIL N	ID		DIY	652	(Detober 25	1,2005
Nº			30. Name and address of person who co	and manner stated. mpleted cause of death (Item 22. Registrar's Signatu	23а) (Туре, Р	Print)	1	4.0		•
T	<u> </u>		Scott Harmall	2 North	Are	nuc 1st	1 Ain	Mary 1.	had 210	14
	Sta		31. Date filed (Month, Day, Year) OCT 2 5 2005	32. Registrar's Signatu	THE COOK			1		
	Registr	ar	UU 1 & 5 2003	ALES OF THE PARTY	-					

Registrar
DHMH 17 Rev 1/2001

State

HEWORFALK

5 2005

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 05 34342 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HUnder 1 Year If Under 24 Hrs. 0 Seneral Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yis. last birthday Birthplace (State or Foreign Country) **Funeral** 213-80-9322 1 M 20 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Madical Examiner must be notified at Director 1ÆYes 2☐No LIZMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? · o Items 23a 21213 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned "natural", or 21215-0036 1 Yes 2 No Specify δ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "eny Injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 125 1125/12/10146 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be PRNE ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES COLEMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Department 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 25 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Pmrt. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emorrhag **Physician** ntracrania Date to (or as a consequence of) /Medical Examiner onai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequende of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of). Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 AUnknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed 1 Yes 2 No of Vital 1 ☐ Yes 2 No Physiclen: To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division or Attending 5 Pending investigation Injury death. 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) an 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygier 20534343 For State Registrar 1-Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 16, 2005 3:55 AM /Medical Name (If not institution, give street and number, or Location of Death 4c. County of Death Examiner Memor 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 1 F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Execultar roughby notified at Funeral Director 1 XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 238 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 🕊 Specify: δ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Tite, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other then Elementary (6dc) ndary (0-12) College (1-4or 5+) (First, Middle, Last) Be 18. Mother's Name (First, Middle, Menta Pages 1 and 2 should be ant's Name/Relationship (Type, Print) b. Mailing Address (Street permit. Pages 1 and 2 to Department of Health ar Important: if item 27 is eny injury or other trauone. Method of Dis osition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE CONGESTIVE Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L fo the Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946F13 OCTOBER 16, 2005. M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL, ZOI E. UNIV. PARKWAY IYENGAR M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 23 Janice Hook Curry 2005 03:45aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Bethesda Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 79 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 211-18-4841 Director 01 - 10 - 1926Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Montgomery Bethesda 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 Democracy Blvd 20817 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 Widowed 4 Nivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Educator Education 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event SDRS. 18. Mother's Name (First, Middle, Maiden Sumame) Robert Clyde Curry Janice Mae Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Curry /son 2643 Centinela Ave #12 Santa Monica CA 90405 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10-25-2005 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Funeral Service Licensee mo1358 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2-No 1 🗌 Yes 2 No Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1-Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the To the Hospital or Attend within 24 hours after deati ▼o the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Zu mo 10124105 00057124 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Iradj Dadgar 9715 Medical Center Dr. Ste 201 Rockville MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 5 2005 Blown & Goods Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 34345 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Virginia Mary Crooks October 21, 2005 3:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 5 (Month) Day. 5. Social Security Number last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 1921 215-18-5262 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exeminer must be notified at MD Baltimore Arbutus Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1301 Birch Ave. 21227 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 10 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: if item 27 is marked other it eny injury or other traumatic event, this 2006. Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Morrow Margaret Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Crooks / son 4705 Wigglesworth Ct. Ellicott City MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 10/24/05 | Baltimore, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signat cense 1328 Sulphur Spring Rd. Arbutus, Maryland 21227 23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Qnset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Metastatic ovarian cancel Physician unknown /Medical Due to (or as a consequence of): Examiner Social fairly list concerns if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 4. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence Other (Specify 1 ☐ Yes 2 No Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attenuers within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 180 MD D24170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEutaw St Bultimore MD 21201 31. Date filed (Month, Day, Year)
OCT 2 5 2005 n. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygion 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 900 Month Year **Physician** Helen AM 2005 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 5527 Ashbourne Rd. Arbutus If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1 1 10 10 11 9 11 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 212-26-7679 1 □ M 2 😡 F 85 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral', or Items 23a or 28a-f show Examiner must be notified at MD Baltimore Arbutus 1 ☐ Yes 21X No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21227 U.S.A. 5527 Ashbourne Rd. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 21€ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Whtie Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: by 3 ☐ Widowed 4 ☐ Divorced "netural", Completed the Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any ijury or other traumatic event once. George Ruhland Lauretta Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Cook/Husband 5527 Ashbourne Rd. Arbutus MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 10-24-2005 Baltimore, MD 4 Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service Acenses Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nlumonia **Physician** /Medical Due to (or as a consequence of): Examiner Au-tic 5 tenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan this certificate has 2 No 1 Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funerel Director; After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D51811 October 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Baltinon imD 11228 Dr. Thomas Ghiorzi 1 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

5 2005

Thomas Carr 05-7154 d1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie () 5 34347

Certificate of Death Reg. No.

1-	State Registrar
1. D	ecedent's

Name (First, Middle, Last)

2. Date of Death Month

Physician /Medical Examiner

al Director

Funeral Director

3a or 28a-f show at be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phy

/M

Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	S. 13.	Was Decedent of If Yes, specify C	ol Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or I no Rican, etc.)	No-
Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Giv.		ne during most of wo tired)	orking	16b. l
Ö		5	Entr	epreneu:			Se
To Be	17. Father's Name (First, Middle, Last, Thomas Henderson	_			18. Mother's Na Georget		dle, Maide mn)
	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Stre	eet and Number or R	ural Route Nun	nber, City
	Thomas H. Carr 20a. Method of Disposition 1 \(\text{M} \) Burial 2 \(\text{Cremation} \) 3 \(\text{C} \) 4 \(\text{Donation} \) 5 \(\text{Other} \) (Specification 1. The state of Furreral Service Licent	Removal from State Dai	lace of Disp emetery, cre clingt	Russel Russel Con Ceme Con Ceme Con Ceme Con Ceme Con Ceme Con Ceme	place)	Lexandr: Date -27-05 Home, P	Dar
	July 17 Klam	astennato		1317 Col	kesbury Ro	oad. Ab:	inado
	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death one cause on each line	. Do not er	nter the mode of o	tying, such as cardia	ic or respiratory	r arrest,
	Immediate Cause (Final disease or condition resulting in death)	a. HEMOPERI Due to (or as a consequence)		MOM			
cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)	uence of):	= Thoru	sic for	275	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	death 3	□Ectopic pregna □ Other (specify,			
by Pr	Part II. Other significant conditions	contributing to death but not resi	ulting in the	underlying cause	given in Part I.	23e. Di	id tobacco
ted						1 [□Yes 2
Completed						24a. What au not not not not not not not not not not	itopsy informed?
Be	25. Was case reterred to medical examiner?	Hospital:			26. Place of De		
7: To	1X Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpation 28b. Time	AUG DON	4 Nursing t	Home 5 ☐ Re 28d. Describ	esidence be how init
ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	_ \	Work? I □ Yes 2 □ No		,
Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, larm, s	street, lactory, offi	се	28l. Location City or 1	n (Street a Town, Stai
edical C	29a. Certifier 1 Certifying Pl (Check only 2 XMedical Example)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea tion and/or	ath occurred at the investigation, in m	e time, date and plac ny opinion, death occ	e, and due to the	he cause(: ne, date ar

3. Time of Death Day Year Thomas Henderson Carr II October 22 2005 9:35 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air
If Under 1 Year | If Under 24 Hrs. Harford 8. Date of Birth (Month, Day,)
Dec. 30, 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 212-96-8558 35 1969 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 Granet Drive 21034 **USA** 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry ervice n Sumame) Conlisk or Town, State, Zip Code) A 22310 Location - City or Town, State lington, Maryland on, Maryland 21009 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day use contribute to the cause of death? 3 Probably 4 □Unknown 24b. Were autopsy lindings available prior to completion of cause of death?
1 → es 2 □ No 6 ☐Other (Specify) ury occurred nd Number or Rural Route Number, s) and manner as stated. nd place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME - Im October 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State

Registrar

MARYARITA

31. Date liled (Month, Day, Year)

OCT 2

KUB

2005 5

32 Megistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Dean Earl October Craven 3, 2005 9:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air 109 South Reed Street Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1⊠M 2□F Yrs. 22, 1953 Maryland Director 212-60-5004 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ns 23a or 28a-f ahow must be notified at 1 Yes 2 □ No Director Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 109 South Reed St. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or Items: 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Private Education Maintenance Man 12 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Lucille Crowley Arvel Haywood Craven 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 South Reed St., Bel Air, MD 21014 Department of Health a Important: If item 27 is any injury or other tra Amy J. Craven / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 remation 3 Removal from State 10-27-05 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland ^{22, Name and Address of Facility}
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service icensee mas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death CARDIDMYOPATHY Immediate Cause (Final disease or condition resulting in death) IDIDPATHIC **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ENSION 3 Probably 4 Junknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DCTOBER \$4 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL ALR & NORTH AVE ANKAR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Salator. Registrar

Please Typ	e or Prin	t in Blac	k indelible ink.	Ensure Al	l Copies Ar	e Legible.

			1 - For Stata Registrar		State of Ma	aryland	/ Depa	rtment of H	lealth an Death	d Ment		e 7 e005	34349
	Physici /Medio		1. Decedent's Name (F LEATRICE	First, Middle, Las A. CEP	•					M	ate of Death Ionth Lober	Day Yes 21 200	
	Examin		4a. Facility Name (If no	_		t mon		4b. City, Town, or	Location of D			4c. County of D	eath
	Funeral Director		5. Social Security Num 219 - 78 - 38	ber 6. S		(In yrs. las		If Under 1 Year Months Days	If Under 24	Hrs. 8. Da	ate of Birth fonth, Day,		Birthplace (State or Foreign Country)
	land		Usual Residence of De 10a. State 10	ecedent 0b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	a-f sh	ctor	MD 8	BALTI MOG	E	PIKES	BVILLE						1 ☐ Yes 2 🔀 No
	with the	Dire	10e. Street and Number	_				10f. Zip Code			10	g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show Effects by Futilized at	Funeral Director	8501 Mour.	MAIN H	12. Was Decedent 6	Ever in U.S.	13. V	21208 Vas Decedent of Hi Yes, specify Cuba		? (Specify Y	es or No-	USA 14. Race - A	merican Indian,
0000	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23a or 28a-f show other traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic event, the McAlcal Exertifier traumatic events are supplied to the traumatic events.	þ	1 🗆 Never Married 3 🗆 Widowed 4 (Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		Yes, specify Cuba	Specify:	uerto Rican	, etc.)	Specify: B	thite, etc.
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lary	2 should I and Meni is marker		19a. Informant's Name	a/Relationship (7	ype, Print)	100		g Address (Street a	an <i>d Number</i> o	r Rural Rou	te Number,		e, Zip Code)
າ ຂ	1 and 2 Health tem 27 i		JANICE GO 20a. Method of Dispos		(SISTER)			MOUNTAIN sition (Name of	HOLLY	DR.		ILLE MD Oc. Location - City	21208
Daillimor	permit. Pages Department of I Importent: if it eny injury or o		1 Burial 2 □ C 4 □ Donation 5 (Cremation 3 ☐ ☐ Other (Specify	•	cem	netery, crem DIAWIN	natory`or other plac	10	.27.05	; B	ALTO - MO	or rown, State
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	/Medical Examiner			(Due to (or as a	a consequer	nce of):						
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O. DOX	The law requires that the death certifies the set of the strending tee has been signed by the attending page 2 should be detached for use a	hysician/M	23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☑ N 9 ☐ Unknown	nths?	23c. If yes, outcome of 1 Live birth 12 Pregnant at 9 Unknown	2 ☐ Fetal de	eath 3	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year
ŗ	signed by	by Ph	Part II. Other significa	nt conditions o	ontributing to death bu	it not resultii	ng in the un	derlying cause give	en in Part I.	2	3e. Did toba	cco use contribute	to the cause of death?
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5	To the Hospital or Attending Physician: The law within 24 bounts after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Matural 2 ☐ Accident	5 Pending investigation	28a. Date of Injur (Month, Day	nt 2□ER y Year) 28	Outpatient Bb. Time of Injury	28c. Injury Work	4 🗀 1401211			ce 6 Other (S	pecify)
	if or Atten after dea i Director d in by the	Certification:		Could not be determined		ry - At home . (Specify)	e, farm, stre			28f. Lo	ocation (Stre ity or Town,	et and Number or State)	Rural Route Number,
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	L.	i i	NIL	ull	M·D			RES	190-	76	0	ctober	21,2005
	8		30. Name and address PRANITHA	NAINI	, SINAL	HOSP17	TAL	F BALTI	MORE	W	Belved	lek Aknu	re Baltimore 21215
	Sta Registr		31. Date filed (Month, I	Day, Year) 2 5 2005	32. Registra	rs Signatur	Loca	K)					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DONOS. Duise OCTOBER 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITEL torBor Baltimol If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01-(7-/9/6 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

NISSISSIPP i **Funeral** Days 1□M 200 F 89 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ehoveny injury or other traumatic event, If a M. Alcal Examinational be notified at once. BATIMORE 1 Yes 2 □ No Director MD, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status I ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DOTTREY 19a. Informant's Name/Relationship (Type, Print) DAU GIHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUTRICIA 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-27-05 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician P105051-C Infarction myocardick UNFROWA /Medical **Examiner** Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires thet the death certificate be executed sete has been signed by the attending physicien and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months2 1 ☐ Yes 2 ☐ NO Month 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate 1 ☐ Yes 2 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 🔲 Inpatient 2 CH/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D0042658 Men october 19, 200, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) η G. Zclow Stepten 3001 South Hanve 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State OCT 2 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 8:42a Raymond Joseph Day, Jr. OCT 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 746 Elmhurst Road Severn Anne Arundel 6. Sex 1 XM 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Director 214-86-7549 36 1968 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits oriant: If Itam 27 is marked other than "natural", or Itama 23a or 28a-1 show Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21032 344 Circle Trail USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Landscaping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raymond Joseph Day, Sr. Donna L. Cutler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Itam 27 Is sny Injury or other trau QDCs. Donna L. Mengele/mother 7987 Nol Park Court Apt. 204 Glen Burnie, MD 21061 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/24/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ²² Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Squomous Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one girlfriend's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) residence 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number DEFENSE HIGHWAY ANNAPOLIS MD 21401 GIENTAM 44 31. Date filed (Month, Day, Year) 13 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			For State	State of Maryland / Department of Health and Mental Hygie	7005 343 53
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	Funeral		5 Social Security Number 6. Sex	Months Days Hours Min Month Day Ye	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	ochber	7931 manyland
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Maryland	0 8 9 1		19a. Informant's Name/Relationship (Ty)		ity or Town, State, Zip Code)
	s 1 and 2 of Health Item 27		20a. Method of Disposition		c. Location - City or Town, State
Baltimore,	Page nent c nt: M ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Garnson Fores: 10/28/05	Wings Mills MD
Bal	permit. Depertir Imports eny inju		21. Signature of Fugeral Service License	22. Name and Address of Facility Exams Func	ral chapel-Beltir
8			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e caused on each line.	Approximate Interval Between
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	
oʻ	be executed icien and burial-transit	Ехаг	that initiated events resulting in death) Last	Due to (or as a consequence of):	
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Box (eath certific attending p for use as	ın/Me	200. Tras decedent pregnant	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery
	the d	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
s, P.O.	es that thighed by	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobact	co use contribute to the cause of death?
Vital Records,	w require been sig should b	sted t	Moderate to	Science Emphysema 1x Yes	2 No 3 Probably 4 Unknown
Rec	The law ate has b page 2 sl	Completed	Type II Dio	belog melikes. 24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ital	- m	Be Cc	25. Was case referred to medical examiner?	1 ☐ Yes 2 € 26. Place of Death (Check only one)	
of V	Phys this al di	ို	1 ☐ Yes 25 No H	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	
ion	ding h. After funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Tyes 2 No	njury occurred
Division of	or Attendition of Attendition of Attendition of the order in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)
	To the Hospital or Attentwithin 24 hours after deati To the Funaral Director: completely filled in by the		29a. Certifier La Certifying Phys	ician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause	e(s) and manner as stated.
	vithin 24 To the Fu	Medical	one) 2 Medical Examin	er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	and place, and due to the cause(s)
	₽ ½ ₽ Ø		29b. Signature and title of certifier	29c. License number 29d. Doo 56607 Oc	Johan 24th 2005
15			30. Name and address of person who con	Dec 56607 October 120 Substitute 23a) (Type, Print) 602 S. ATWOOD Ro	1 1.7 1.50
	Sta	te	JOSEPH ANC 31. Date filed (Month, Day, Year)	A 32. Registrar's Signature	x, 13ELPTIK MU2101
13	Penietr	_	OCT 9 5 2005	Here A. J. Works	

MELVIN

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F	lealth and N <i>Death</i>	/lental Hyg	gienez (05	34354
	Physici /Medic		1. Decedent's Name (First, Middle, La BLANCHE,		VTIS			2. Date of Dea Month	Day	2005	3. Time of Death
7	Examin		4a. Facility Name (If not institution, give East Point Rehab		enter	4b. City, Town, o	r Location of Death		4c. Coun Balti	ty of Death	
	- Funeral Director		216-24-1167	. C. u. a. Y. c.	e (In yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar. 4,	v Year)	9. Birthpi Coun Mary	lace (State or Foreign try) land
	show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10	0d. Inside City Limits
	with the N a or 28a-f	Director	MD N/A 10e. Street and Number 4216 Dayloigh Roa	d	Baltimore	10f. Zip Code 21236			10g. Citizen o	f What Coun	
336	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "natural", or Itama 23a or 28a-f show event, the Modifiel Experience, usel be multified at	by Funeral	4216 Darleigh Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 H	No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:			ace - Americack, White, e	etc.
Maryland 21215-0036	within 72 hor jiene. ir then "naturi its Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	sing	16b. Kind of		dustry
land ?	should be filed and Mental Hygis marked other matic event, I	To Be C	17. Father's Name (First, Middle, Last Joseph P. Rainald		,		18. Mother's Nam Carmela				
	nd 2 s ulth ar 27 is r trau		19a. Informant's Name/Relationship (Alfred L. DeSanti			ng Address <i>(Street</i> Darleigh					Code)
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 XBurial 2 Cremation 3 5 4 Donation 5 Other (Speci		20b. Place of Dispo cemetery, cre Gardens o	matory`or other plac	10/2	Date 4/05 E	20c. Location		
Balti	permit. Pages Department of Important: If I eny injury or once.		21. Signafure of Fineral Service laice	Den	100	2. Name and Addre	,		1050	York F n, MD	Road
Acces 1	Physician		23a. Part 1. Enter the disease, or com shock, or heart faifure. List only fmmediate Cause (Final disease or condition	plications that caused one cause on each li	the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	Sequentially list conditions, it any set in a commercial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as	a consequence of						
8760,	icate be executed physician and s the burial-transit	dical E		d	a consequence of);						
O. Box 6	that the death certific led by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>	,			ate of deliver	ry Day Year
<u>α</u>	es that gned b be deta	þ	Part If. Other significant conditions	contributing to death b	ut nof resulfing in the u	inderlying cause giv	en in Part I.		bacco use col	ntribute to the	e cause of death?
Vital Records,	The law ate has b page 2 s	Completed						24a. Was a autop perfor	sy	Were autop prior to con death? 1 \(\sum \text{Yes} \)	osy findings available inpletion of eause of 2 PNo
of Vita	Physician: this certific ral director,	To Be	25. Was casa referred to medical examiner? 1 Yes 2 No	Hospital:			4 Nursing Ho	ome 5□Resid	ence 6 🗆 O)
Division of	Attending Fir death. ector: After by the funer	Certification:	27. Mann of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		y Year) Injury	M 1 🗆	y at k? Yes 2 □ No	28d. Describe h			
Divi	를 를 들	Certif	4 Homicide determined	building, et				28f. Location (S City or Tow	n, State)		
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	of ity knowledge, deat f examination and/or in ated.	vestigation, in my o	pinion, death occur	red at the time, o	date and place	, and due to	the cause(s)
	To To Con	-	29b. Signature and title of certifier			D 5	7727	-	29d. Date sign	2/	05
SI-			30. Name and address of person who	Chans	eath (ftem 23a) (Type,	Wanh	et ble	rle I	and	alk.	MD21222
10	Sta Registr		31. Date filed (North Day, Year) 0CT 2 5 2005	32. Registr	ar's Signature	and the second					

			for State Registrer	State of Maryland	d / Depa <i>Cer</i>	artment of F tificate of	lealth and l <i>Death</i>		ien 200	5 34355
	Physici		1. Decedent's Name (First, Middle, Last)	+ DUKES	5			2. Date of Dea Month		(ear 10 14 a M
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give si MATURAL GP NETIL 5. Social Security Number 6. Sex 249 · 08 · 1404			4b. City, Town, of the City, Town, of the City of the	If Under 24 Hrs. Hours Min.		4c. County of	
	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo		, <u></u>			10d. Inside City Limits Yes 2 \(\text{No} \)
	or 28a-f	Directo	10e. Street and Number	- CL	DHO	10f. Zip Code	2/2/7	1	0g. Citizen of Wh	nat Country?
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Medical Examinal must be mulified at	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of H f Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
21215-003	vithin 72 hours ne. han "natural" e Medical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of wor d)	king	16b. Kind of Bus	iness/Industry
Maryland 21	permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is markad othar than "natu any injury or othar traumatic evant, IL e Medical onge.	To Be Col	17. Father's Name (First, Middle, Last) CHARLES RO	BINSON		VANITO	18. Mother's Nan	ne (First, Middle, HERNE	Maiden Sumame,	ES
	s 1 and 2 sho f Health and item 27 is ma othar trauma		20a. Method of Disposition	(BROTHER)	3830	sition (Name of	and Number or Ru	E. BACI Date	MORE / 20c. Location - C	MD 21213 ity or Town, State
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 Burial 2 Veremation 3 Re '4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	e State	EENMOJ 22 1	Name and Addre	MTDAY /A	Vath C.	DACTIM BREENE TIMORE	ORE, MARYUME FUNERAL HAM , MO 21212
58760, ^	/Medical- Examiner bhysician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence) Billary Due to (or as a consequence) Billary Due to (or as a consequence) Markas Fah	uence of): Ative uence of): black true uence of):	sepsis action	6		651,	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifics ate has been signed by the attending ploage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna. 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont	of delivery h Day Year
	uires that t signed by d be detac	Ď	Part II. Other significant conditions con A Cute Renal		ulting in the u	nderlying cause gi	ven in Part I.			oute to the cause of death?
I Records,	The law requir ate has been si page 2 should l	Completed						24a. Was a autop: perfor 1 ☐ Yes	sy pri med2 de	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No
Vita	sician: certific irector,	o Be (25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ott		ath (Check only or		(Spacify)
on of	ding Phy n. After this funeral d	 	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju Wo			ow injury occurre	
Division of Vital	To the Hospital or Attanding Physician: The I within 24 hours after death. To tha Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify				28f. Location (S City or Tow		or Rural Route Number,
	e Hospit 124 hours a Funera letely fille	Medical O		ician: To the best of my knowner: On the basis of examinat and manner stated.						
)	To th within To th compl	Me	29b. Signature and title of certifier Braining) u.o.		29c. Licen:	se number 502	2	9d. Date signed 10 - 15 -	(Month, Day, Year)
	1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) Gare	ral Horr	ital		
:	Sta Regist		31. Date filed (Many Collay, 2 ear 200	5 3 Registrar's Signa	Y .) (solis	an inerp			

	-		State = State Amend Item 5&7&Unper Registrar	of Maryland / Deparend Item 23a_27	tment of Health and I 28a-f per me G84 Ificate of Death	Mental Hygie n 49 11-18-05 Reg. N	Q 15 3	34356
*	Physicia		1. Decedent's Name (First, Middle, Last)	O_{ℓ}	IKE		ay Year	3. Time of Death 4:19 A
	/Medic Examin		4a. Facility Name (If not institution, give street and r	number)	4b. City, Town, or Location of Death		20, 2005 Ic. County of Death	4:19 A
7			University of Maryland 5. Social Security Number 6. Sex	Shock Trauma 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birtho	lace (State or Foreign try)
K	Funeral Director		108-14-7582 1□ M 210/F	86 Yrs.	Months Days Hours Min.	OCT. 18	919 Ne	Wyork
)	how	_	Usual Residence of Decedent 10a. State 10b. County	10c. City Town or Loc	ation		10	0d. Inside City Limits
	ith the Marylar or 28a-f show	recto	10e Street and Number	re Park	10f, Zip Code	10g. C	Citizen of What Coun	1 Yes 2 No
	23a or	rai Di	3 D Luddy	ct.	21234		USA	•
980	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-f show the Modical Exeminar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, 3 Wildowed 4 Divorced	s 2 M/No Give	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other than "natural; other traumatic event, the Medical Ext	Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) (Give k	ent's Usual Occupation ind of work done during most of wor O NOT use retired)	king 16b.	ort H	ome
Maryland	2 should be filed and Mental Hygi Is marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) MICHOE SOSKI 19a. Informant's Name/Relationship (Type, Print)	WICZ	18. Mqther's Nar Hele Address (Street and Number or Ru	ne (First, Middle, Maide NEVA	inko	Code
	Tand 2 sl Health and tam 27 is r		John R. Duk	1069	o Buice ri	d. Alpho	iretta,6	TA 30022
Baltimore,			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	m State 20b. Place of Dispos cometery, crem	atory or other place)	21/05 Fo	rest Hil	II MD
Balti	permit. Page Depertment of important: If any injury or once.		21 Signature of Empral Service Licensee	22.	Name and Address of Facility E	lans Cha	pel of m	emories
	A 14		23a. Part F. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not enten each line.	r the mode of dying, such as cardiac	or respiratory arrest,	- Comb	Approximate Interval Between Onset and Death
	Physician /Medical			Injuries to (or as a consequence of):				
F .	Examiner	ت.	Sequentially list conditions, b. Due	to or as a consequence of :				
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8760,	icate be executed physicien and s the burial-transit	dicai E	d.	(0. 40 2 00.100400.100 0.).				
Box 6	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as to	Physician/Med	in the past 12 months?	egnant at time of death 5 🗌	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
ds, P.O	ires that the signed by	þ	Part II. Dther significant conditions contributing to	death but not resulting in the un	derlying cause given in Part I.		use contribute to th	e cause of death?
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/ / Vital	yeiclen: The Is certificate his director, page	Be Co	25. Was case referred to medical examiner?		26. Place of Dea	1 2 Yes 2 □ N ath (Check only one)	No 1 es	2 No
of C	Phyeic r this ce ral dire	၉	1X Yes 2 No Hospital: 1	Inpatient 2 R/Outpatient te of Injury 28b. Time of	3 DOA Other: 4 Nursing H	lome 5 Residence)
ion	uttending Ph death. ctor: After thi y the funeral	ation	1 Natural 5 Pending investigation	76 Day Year) Found 12:00	a ^M 1 □ Yes 2 No	Subject fo		steps
Division	after de Directe d in by th	Certification:	3 Suicide 6 Could not be determined 28e. Pla bu	ace of Injury - At home, farm, stre ilding, etc. <i>(Specify)</i> ad outside resid	et, factory, office	28f. Location (Street: City or Town, Sta Parkville,	and Number or Rura Ite) 1 D Ludo MD 21234	Route Number, ly Court
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	edicai C	(Check only Medical Examiner: On the	the best of my knowledge, death be basis of examination and/or invi- anner stated.	occurred at the time, date and place estigation, in my opinion, death occurred.	, and due to the cause	(s) and manner as st	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1,	29c. License number OCME		Date signed (Month, I	•
	\mathcal{N}		30, Name and address of person who completed co	Buse of death (Item 23a) (Type 5	erint) 111 Penn Stree		cober 20, ce, Maryla	
7			THE OF VIEW KING		, III ICIII DELEC	c bartimor	.c, maryta	
**	Sta Regist		31. Date filed (Month, Day, Year) 5 2005	. Registrar's Signature	(L)			

		1	1 - State Registramend Item #19a			epartment of I C en tificateof			iene 2005	34357
	Physici	an	Decedent's Name (First, Middle, Last)	a ici iii	1. 0049	11/01/07	л	2. Date of Deat		3. Time of Death
	/Medic	al	Preston 4a. Facility Name (If not institution, give stree		ck		avis or Location of Death	October	4c. County of Dea	3 Ziola M
	Examin - Funeral	er	Maryland Gener 5. Social Sedurity Number 6. Sex	0 HOS	Dita In yrs. last birth	BOILING day) If Under 1 Year	or (if	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
40	Director	Œ.	213-12-2365 XXM	^{2□ F} 8	5 Y	rs. Months Days	Hours Min.	06 04		SC
	yland Now		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
	ith the Marylar or 28a-f show e notified at	Director	MD NA		Baltin	nore				X☐Yes 2☐No
	death with the Maryland rme 23a or 28a-f show rmust be rigitined at	Dire	10e. Street and Number	ha Ch		10f. Zip Code	1000	1	0g. Citizen of What C	
	death w	Funeral	2411 West Lexing 11. Marital Status 12. V	Vas Decedent Evermed Forces?		13. Was Decedent of I	1223 Hispanic Origin? (Sp	ecify Yes or No-	U . S . Z	erican Indian,
980	72 hours after death with the Maryla natural; or itame 23a or 28a-f shov disal Examinat must be notified at	by	1 Never Married 2 Married	Tyes 2 No f Yes, Give rear or Dates:		1 ☐ Yes 2 X No		nican, etc.)	Black, Whi	Black
5.6		olete(15. Decedent's Education (Specify only highest grade con	npleted)	(Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Business	s/Industry
212	e filed within al Hygiene. I other than "	Completed		College (1-4or 5+) na		Post Car			Post Of	fice
pu	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
S _i st	2 should be and Mental Is marked c	2	Lee Davis Jr. 19a Informant's Name/Relationship (Type, I	Print)	19b.	Mailing Address (Street	Amanda tand Number or Run		, City or Town, State,	Zip Code)
S/I	ges 1 and 2 should be filed within tof Health and Mental Hygiene. If Item 27 Is marked other then or other traumatic event, IL & M.		19a Informant's Name/Relationship (Type, Ellen Catherine Dor Ellen Davis-Daug	kins ater	32	09 Burnb	rook Lan			
Ore	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition ✓ Burial 2 Cremation 3 Remo	val from State		Disposition (Name of crematory or other pla			20c. Location - City of	
a time	그 든 문 글		4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenstee	1 / 0	Balti	more Nat		/28/05	Baltimor	ce, Md
	Depa Impo any it		Allenia no	Kek	<u> </u>	March F/1	H West	Baltin	more, Md	21215
j e.	. \$\delta_{\text{\ti}\text{\ti}}\\ \ti}\\\ \text{\text{\text{\text{\text{\text{\text{\text{\tex{\tex		23a. Part1. Enter the disease, or complication shock, or heart ailure. List only one complications are complicated to the complex of the comp	ons that caused that each line.	ne death. Do no	at enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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P.O. Box	 Hospitel or Attending Physicien: The law requires that the death certificate hours after death. Funerel Director: After this certificate has been signed by the attending by Funerel Director after this certificate. Finely filled in by the funeral director, page 2 should be detached for use a leily filled. 	Physician/M	in the past 12 months?	f yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	ey .		23d. Date of de Month	olivery Day Year
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X.	ding Physicien: h. After this certific funeral director,	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☑ No Hosp	ital:	2 □ ER/Outr	patient 3□ DOA Ott	26. Place of Death		e) ance 6 □Other (Spe	acify)
u of	ng Phy fter thi ineral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	8a. Date of Injury (Month, Day)					ow injury occurred	out,
isio	ttendi death. stor: A	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Ro. Place of Injun	/ - At home far	M 1 [m, street, factory, office	Yes 2 □No	28f Location (St	reet and Number or F	hural Pauta Alumbar
Div	el or A s after il Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	n, street, ractory, office		City or Town	n, State)	urar noute Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physicis 2 Medical Examiner:	n: To the best of On the basis of eand manner state	xamination and	death occurred at the ti	ime, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licen:	se number	110 P	9d. Date signed (Mon	th, Day, Year)
	1		30. Name and address of pason who compl	eted cause of dea	ith (Item 23a) /	vpe. Ptinti.	XTU	77 6	CTUDET.	12,2005
<u> </u>	l .		Ikenna Nwach	uKwu	, M.D.	Clolka	ryland	Gene	ral Hos	pital
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 5 2005	32. Registrar	s Signature	Coente	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hyginh

			1 - State Registrar	olato or marytame	Cer	tificate of	Death		g. No.	0 4 0 0 0
**	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death	2 ^{Day} , 200 ^{Year}	3. Time of Death
	/Medic	al	ANNA LEE 4a. Facility Name (If not institution, give	DIETRICH		4b. City. Town. o	or Location of Death		4c. County of Death	12:07 A M
	Examin	er	WALDORF HEALTHCAR				.DORF		CHARLES	
*	Funeral Director		213-18-6237	7. Age (In yrs. las	Yrs.	II Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 9,	Year) Col	place (State or Foreign intry) th Carolina
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	sa-f st	Director	Maryland Charles	County	Bryan	town				1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Code	20417	10	g. Citizen of What Cou	intry?
	death ms 23	Funeral	6195 Bryantown Dr	12. Was Decedent Ever in U.S.	13. \	Was Decedent of H	20617 Hispanic Origin? (Sr	pecify Yes or No-	USA 14. Race - Amer	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28s-f show or other traumatic event. The Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No	an, Mexican, Puerto	Hican, etc.)	Specify: W	nite
15 15	n 72 h "natu edical	Completed	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of work	king	6b. Kind of Business/li	ndustry
72	s within piene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	o)		Own Resid	lence
פ	al Hyg	Bec	17. Father's Name (First, Middle, Last)		TION	C-IIII II C-I	18. Mother's Nam	e (First, Middle, M		
<u>ya</u>	should be nd Mental marked c	To	Crawford	Heath_	10b Mailia	- Address (Chron			ance Rober City or Town, State, Zi	
Baltimore, Maryland	and 2 shealth and n 27 is n		19a. Informant's Name/Relationship (Ty Ann H. Lancaster	(Daughter)		•			wn, Marylai	
ore,	of Hea of Hea of Itam rothe		20a. Method of Disposition	20b. Plac		sition (Name of natory or other pla			20c. Location - City or T	
Ē	Pages Iment of I tant: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Loud	lon Pa	ark Cemet	ery 10/2		Baltimore,	
Bail	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other other.		21. Signature Houserst Service to as Martin D. I. W. 23a. Part. Enter the disease, or compl	Laws	M M	Name and Addre litchell- 500-York	wiedefeld Road, Ba	l Funeral	Home, Inc	21212
X			shock, or near failure. List only of	ne cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	CAOTI	C CAA	DIOCKISC	UHR	DISSASE	YEARS
Ğ.,	Examiner		Out and the first are divined	Due to (or as a conseque	nce or,					
7	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce ol):					
v	rtificate be executed ng physicien and s as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce ol):					
68760,	ysicier ysicier		L.	d						
		Medical	IF FEMALE:							
.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the bunat-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3	Ectopic pregnanc Other (specify)	y		23d. Date of deliv Month	rery Day Year
s, P	es that igned b	by Pt	Part II. Other significant conditions con		ing in the u	nderlying cause gr	en in Part I.		acco use contribute to	the cause of death?
ord	w requir been si should	eted	INITESTIVAL	LUNG 1	1(324	+75				bably 4 ∐Unknown
Division of Vital Record	The larate has	Completed						24a. Was ar autopsy perform 1 \(\sum \text{Yes} \) 2	prior to co	opsy findings available ompletion of cause of
Ĭ	Physicien: Tribis certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▶ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	2/Outpatien	t 3 DOA Ott	100	th Check only one	nce 6 □Other (Spec	£.)
ا م	ਦ = <u>ख</u>	J	27. Manner of Death		8b. Time of			28d. Describe ho		19)
sior	Attending r death.	catic	1 SNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □No			
<u>></u>	l or Atten after deatl Director:	Certification:	4 Homicide determined	28e. Płace ol Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		281. Location (Str City or Town,	eet and Number or Rui State)	al Route Number,
_	Hospite 4 hours Funeral ely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge. ner: On the basis of examination and manner stated.	edge, death n and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and mainter states.		29c. Licens	se number	29	d. Date signed (Month)	Day, Year)
			111	->		D-	18242	C	OFFER:	21, 2005
	10		30 Name of react person who co	ompleted cause of death (Item 2	(Type,	Print)	rs /C/A	50 11	CACOPER:	ld Takes
	Sta	te	31. Date filed (Month, Day, Year)	32. Aegistrar's Signatu			اد ما	CI V	- A JOLY A	M. Will
N.	Registr		OCT 2 5 20	05 Brown D	S. P.					

ERLIN	
JOSEPHINE	

			State of Maryland / De	partment of Health and Mental	-
			1 - State Registrar Co	ertificate of Death	Reg. No.
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Josephine E'RLINE	2. Date of Month	22 2005 11:20PM
-	Examin	er	4a. Facility Name (If not institution, give street and number) STELLA Maris Hospice	4b. City, Town, or Location of Death	4c. County of Death 13 A LTIMOLE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	v) If Under 1 Year If Under 24 Hrs. 8, Date (of Birth 9. Birthplace (State or Foreign
1	Director		212-75-3646 1□M20F 90 Yrs. Usual Residence of Decedent	Sep 7	-27,1915 150
	with the Maryland a or 28a-f show	ctor	10a. State 10b. County 10c. City, Town or	BALTIMER	10d. Inside City Limits 1
	ath with the 23a or 28 ust be no	al Director	10e. Street and Number 7604 BAGIEY AVE	101. Zip Code 2 1234	10g. Citizen of What Country?
936	after dea or items	by Fur		3. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: Wh. Te
Maryland 21215-0036		Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
land 2	be filed ital Hygi of other event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles Corso	18. Mother's Name (First, M	iddle, Maiden Sumame) Rosario
Mary	and aum		19a. Informant's Name/Relationship (Type, Print) 19b. Ma MICHGEL ERLING 760	iling Address (Street and Number or Rural Route N	
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 I iry or other tra		20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	position (Name of rematory or other place) COD CEM. Date 10 36 65	20c. Location - City or Town, State Bolte MD.
Balti	permit. Pages Department of Important: If any injury or any injury or		21. Signature of Funeral Service Licensee Stella	22. Name and Address of Facility 5 Tella	Tuneral Home CHD. He MO 21234
養養	Physician		23a. Part . Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respirate	ory arrest, Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	ACCIDENT	
8	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
,092	certificate be executed triling physician and use as the burial-transit	cal	resulting in death) Last Due to (or as a consequence of): d		
89 x	entifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		
P.O. Box	death Batter d for u	Physician/Medi	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
	es the	δ	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,		Completed			Was an autopsy autopsy findings available prior to completion of cause of death? √es 2 ♥ No 1 □ Yes 2 □ No
Vita	ician: T	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death Check of	
on of	ding Phys h. After this funeral dii	tlon: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Accident Investigation	of 28c, Injury at 28d, Desc	Residence 6 *** Other (Specify) HOSPICE pribe how injury occurred
Division	I or Attendi after death Director: A I in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Locat	ion (Street and Number or Rural Route Number, or Town, State)
_	To the Hospital or Attivition 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier (Check only one) X Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due to investigation, in my opinion, death occurred at the times.	time, date and place, and due to the cause(s)
	To the P within 24 To the F complete	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	V		30. Name and address of person who completed cause of death (Item 23a) (Typ		
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 5 2005 OCT 2 5 2005 OCT 2 5 2005		21093
A.	, regist		JOIN O LOUS JURISIES JO J	177.07.2	

			1 - For State Registrar	State of Mary	land / De/ C	epartment o Certificate	f Health and Of Death		iene 0 0 5	34361
	Dhysisi	on.	Decedent's Name (First, Middle, La	st)				2. Date of Deat		3. Time of Death
	Physici /Medi			M. Everly	Y			Octobe:	r 24, 200	
1	Examir	er	4a. Facility Name (If not institution, given Brighton G				m, or Location of D		4c. County of Dea	
	Funeral		5. Social Security Number 6. S	ex 7. Age (II	yrs. last birtho	(ay) If Under 1 Y	ear If Under 24 h	Hrs. 8 Date of Birth	Q Rie	tholace (State or Foreign
	Director		235-74-2407	□M XIXF 9	3 Yr.	s. Months Da	ays Hours N	Min. Oct. 11	, 1912 W	.Virginia
	land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	r Location				10d. Inside City Limits
	Mary a-f sh	ţō	W. VA. Prest	on	King	роом				1 Yes XXNo
	ith the	Director	10e. Street and Number	1		10f. Zip Co	de	10	0g. Citizen of What C	ountry?
	e 23a	ral	1906 Milford				26537		U.S.	
	ter de r ttem Iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes XXNo	r in U.S.	13. Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whi	
8	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or teme 23a or 28a-f show thit, the Medical Examinar must be multified at	by	XXWidowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes ※ ※	No Specify:		Specify: V	√h i te
5	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. D	ecedent's Usual Or	ocupation one during most of stired)	working	16b. Kind of Business	/Industry
12	withir iene. then	ошо	Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		Homemak			Own Ho	ome
פ	be filed stat Hyg od other	BeC	17. Father's Name (First, Middle, Last,					Name (First, Middle, M		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at	To	George Washin					<u>lvie Jane</u>		
Mar	12 sho hand 7 le m traum		19a. Informant's Name/Relationship (1			Rural Route Number,		
	Health tem 27 other tr	l i	J. Donald Ever 20a. Method of Disposition			isposition (Name of crematory or other		.; Baltin	NOTE, MD 20c. Location - City or	
altimore,	Pages nent of l int: If it		1 ☐ Burial 2 X X remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	memovar nom State			ı	10/25/05	Baltimo	ore. MD
Salt	permit. Page Department of Important: If eny injury or once.		21. Signatury of Funeral Cervice Licer			22. Name and Ad	dress of Facility E	ckhardt F	uneral C	hapel P.A.
m 	g ∪ ≅ ∌ g		Jane 1	m						11s,MD2111
	D		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Atheros			iovascula	r pisea	se	
	Examiner		Sequentially list conditions,	h						
	ed sit	lner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nisequence of)					
	xecution and al-tran	Examin	that initiated events resulting in death) Last	c Due to (or as a co	insequence of):					
68760	ficate be executed physicien and is the burial-transit	edical		, d						
_	entifica ing ph e as th		IF FEMALE:							
Box	eath certif attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date of de Month	livery Day Year
Р. О	the de	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	50106411	3 🗆 Other (specil)	7			
	The law requires that the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions of	ontributing to death but no	ot resulting in th	e underlying cause	given in Part I.		acco use contribute to	
ord	w require been si should t	eted						_ 1	s 2□No 3□Pr	obably 4 Honknown
Rec	The law cete has b page 2 s	Completed						24a. Was an autopsy perform	24b. Were au prior to death?	utopsy findings available completion of cause of
ta		0	25. Was case referred to medical				26 Place of I	1 ☐ Yes 2 Death (Check only one	Yes 1 ☐ Yes	2 2 No
<u> </u>	hysician: nis certific I director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	itient 3 DOA	Othor	g Home 5 ☐ Reside		city) Civing
Division of Vital Records,	Attending Physician: or death. ector: After this certifice by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Tim lnju		njury at Work?	28d. Describe ho	w injury occurred	
<u>ISI</u>	Attend death ctor: y the	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	12	At home, farm		1 ☐ Yes 2 ☐ No	28f. Location (Str	eet and Number or Ri	ıral Route Number
á	s after of Dire	Certification;	4 Homicide	building, etc. (S	Specify)			City or Town,	, State)	
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fun	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/o	eath occurred at the investigation, in r	e time, date and plany opinion, death of	ace, and due to the ca ccurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier				ense number		d. Date signed (Mont	
)			> Kaun & &	Palrtt, M.	₽.	Do) F 08 200	0 0	ctober 2	5, 2005
_			30. Name and address of person who Karen L. Babitt	M.D. 25 M	ain stre	et, suit	e 200, Re	isterstow	on, MD 2	1136
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 5	32. Redistrar's	Signature	Sparke				

	-	For State Registrar	State of Maryla	and / Depa			Mental Hyg	•	34362
Physiciar /Medica Examine	1	1. Decedent's Name (First, Middle, Li NICHOLAS 4a. Facility Name (If not institution, gi	DAVID	EATO	4b. City, Town, o	or Location of Deatl	2. Date of Dea Month	th Day Year 19 200 4c. County of Dea	o5 10:04 M
Funeral Director				rs. last birthday) Yrs.		If Under 24 Hrs. Hours Min. 9	8. Date of Birth (Month, Day Oct 19	PRINCE (Year) 9. Bi 2005 Ma	E GEORGES httplace (State or Foreign country) ryland
or 28e-f show	OII SCOOL	MD Prince (George's	Oxon Hi	11 10f. Zip Code	07/5	1	0g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No country?
4215-0036 within 72 hours after death with the Maryland ene. than "natural, or items 23e or 28e-f show the Nedical Evantural rust be inclined at	Dy Luncian	6517 Livingston 11. Marital Status 1 ↑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes, 2 No If Yes, Give X Year or Dates:			0745 Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race - Am Black, Wh Specify: b.	ite, etc.
O B D B		15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	cade completed) College (1-4or 5+) none	(Give	OO NOT use retire	during most of word		16b. Kind of Business	s/Industry
Maryland of 2 should be fill th and Mental Hy t7 is marked oth traumatic even	200	17. Father's Name (First, Middle, Las David Eator 19a. Informant's Name/Relationship Southern Marylar	1 (Type, Print)			Tanish		r, City or Town, State,	Zip Code)
Baltimore, N permit. Pages 1 and Department of Healt Important: If item 27 any injury or other 1 once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 (□Removal from State	o. Place of Dispo cemetery, cre	osition (Name of matory or other pla	сө)		20c. Location - City o	r Town, State
			Wade Direct	o r S ∣B,	tate Anat altimore,	omy Boar MD 2120	01	Baltimore est,	Approximate Interval Between Onset and Death
S8760, licate be executed Physician Ph	ز	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons	sequence of):	. (0)	15 gn			
The law requires that the death certificate be the has been signed by the attending physicia page 2 should be detached for use as the burnarioted by the Dhysicial and Medical	- 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preduction of the second of the se	etal death 3[□Ectopic pregnanc	у		23d. Date of de Month	blivery Day Year
requires	2	Part II. Other significant conditions	contributing to death but not i	resulting in the u	inderlying cause gi	ven in Part I.	1 □ Y	es 2 □ No 3 □ F	to the cause of death?
Vital Rec sicien: The law certificate has t irector, page 2 s	pe combiered	25. Was case referred to medical examiner?					24a. Was a autops perfore 1 Yes	red? prior to death? 2. No 1 □ Ye	s 2□No
n of ng Phy Ifter this uneral d		1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not	he -	28b. Time o Injury	f 28c. Inju Wo M 1		28d. Describe ho	ence 6 Other (Special Control of	
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	cal certifi	4 Homicide determined	building, etc. (Spe	ecify) knowledge, deat	h occurred at the ti		City or Town	ause(s) and manner a	s stated.
To the Hosp within 24 hou To the Fune completely fil	Medi	29b. Signature and title of certifier 30. Name add address of person who	miner: On the basis of exame and manner stated.		29c Licens	se number	2	9d. Date signed (Mon	
State Registra		31. Date tiled (Month, Day, Year)	32. Registrar's Ski	mille	Ho-	spital	Jary	Thene m	Vergara

State of Maryland / Department of Health and Mental Hygiene 34363 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month October 16 2005 Mariam Carroll Fino 13:51 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choice Lane #629 Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 9. Sept. 5, 1917 Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 220-24-3033 88 Yrs. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinational be retified at 1 ☐ Yes 2 No Director Maryland Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane #629 21228 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Innortent: If item 27 is marked other than "natural", or Iten eny injury or other treumatic event, the McCeal Examinat 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George C. Dunaway Mary Lillie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 3330 Flickinger Road Westminster, Maryland 21158 Mark J. Fino 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Crestlawn 10-21-2005 Marriottsville, MD 21. Signature of meral, ervice Linensee ^{22. Name and Address of Facility}
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) My210dy5019519 Priysician MUS /Medical Due to (or as a consessionce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burial-transit completely filled in by the furneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2€ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SA Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies ND October 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caturoville. March Chuice Gre Andrew contra 711 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 2 5 2005 Registrar

			1 - For State Registrar	State of M	aryland		artmen <i>tificat</i>			ind M	lental Hy	giene Reg. 2. 0	05	3436	54
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La Paul Francis Aa. Facility Name (If not institution, giv	FitzGerald			4b. City,	Town, or	Location of		2. Date of De Month DCTOBE	Day 20.	Year 2001; unty of De		Death A M
	Funeral		Saint Joseph 5. Social Security Number 6. S		je (In yrs. la	ast birthday)	If Under	1 Year Days	If Under 2	W S 0 1 24 Hrs. Min.	8. Date of Bir	th ay, Year)		thplace (State or ountry)	Foreign
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	with the Ma Se or 28a-f	i Director	MD Balti 10e. Street and Number 805 Providence R		Tou	JSON	10f. Zip	Code 1286				10g. Citizen	of What C	•	2X No
9036	d within 72 hours after death with the Maryland liene. Iten "natural", or Items 23a or 28e-f show triben matural", or Items 23a or 28e-f show the Markler Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates:		тт '		dent of His		jin? (Spe Puerto	ecify Yes or No Rican, etc.)			erican Indian,	
Maryland 21215-0036	within jiene. r than	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)		dent's Usua kind of wor DO NOT us al Of	rk done d se retired) fice	uring most			16b. Kind o	vy	:/Industry	
ryland	should be fited and Mental Hygie marked other in	To Be	17. Father's Name (First, Middle, Last) Christopher Fit 19a. Informant's Name/Relationship (zGerald		19h Mailin	a Address		Mar	y Cl	(First, Middle aire If Route Numb	McNama	ra	Zio Codol	
	is 1 and 2 of Health a item 27 is other train		Martha FitzGeral 20a. Method of Disposition 1□Burial 2♀Cremation 3□	d/wife	ce	805 P: ace of Dispo metery, cren	rovid sition (Nam natory or o	ence	Rd.,	Tou	on, M	arylan 20c. Locati	d 21 on - City o	286 Town, State	
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (Specifical Signature of Pince rall Septical Licen	1)			. Name an	d Address	s of Facility	Ruc	21/2005 k Tows uson, Ma	on Fun	eraĺ	Maryland Home, In O4	
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P.O. Box 68760,	The law requires that the death centificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetal	death 3	Ectopic pro					23d.	Date of de Month	livery Day Ye	ar
	w requires that been signed b should be deta	by	Part II. Other significant conditions of CHRONIC OBSTRUCT					ause give	n in Part I.		23e. Did t			the cause of dearobably 4 🗆 U	
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1X Inpatie 28a. Qate of Inju (Month, Da	ry 2	R/Outpatient 28b. Time of Injury		A Other Bc. Injury Work	T 4 □ Nurs	sing Hon	(Check only one 5 Resident Res	dence 6		ocify)	
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e .	Sta Registr		30. Name and address of person who of ABDALLAH J. HE 31. Date filed (Month, Day, Year) OCT 2 5 200	OU M. D.	75 (ar's Signatu	21 OS	LER			OWSC	IN MAR				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiere 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:37 PM Charles E. terp 20 2005 october /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore wishington medical Center

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6161 Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Dec 3, 1926 Director 212-20-3165 78 MD Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Directo Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 238 1420 Gordon Drive 21061 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give Year or Dates: 19 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1945 1 Never Married 2 Married ŏ 1 ☐ Yes 2X No Specify: 1946 3 ☐ Widowed 4 ☐ Divorced White "natural", 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NDT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Sheet Metal Extrusion Aluminum Plant 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F is marked of Be P Charles Ellis Ford, Sr. Laura Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 Gordon Drive, Glen Burnie, Maryland 21061 Mrs. Bernadette A. Ford / wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 10/24/2005 Stevensville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, P.A. MO1357 1 Second Ave SW, Glen Burnie, MD 21061 Paneure Approximate Interval Between Onset and Death 23a. Part1. Energibe disease, or complications that caused the death. Do not enler the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Levehrouascular accident **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Dotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) The law requires that the death certificate be executed acute myocardial Due to (or as a consequence of): Box 68760, Physician/Medical as 980 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 6 Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown duegi 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cardiomyonath autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Empatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after in 24 hours. the Funeral Dire 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a, Certifie and manner stated within 2 thai 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number mp D0022483 October 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nospital Dr. Glen Burnie, MD 21061 305 lacchs 35. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 5 2005 Registrar

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2

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10-19-2005 Frances Farley 9:53 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mariner Health of Glen Burnie Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🕱 F Hours Director Yrs 3-27-1915 447-30-9862 90 Germany Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23e or 28a-f show other treumatic event, it a Modic. Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Glen Burnie MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 Hamlen Road 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filled within 72 hours after on and Mental Hygiene. Is marked other then "naturel", or Iter 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White þ Specify: 3 ☐ Widowed 4XCXDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Chevron 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Clare Roschald ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: ff item 27 Is m any injury or other treum Hansel Farley / Son 718 Hamlen Road; Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 10-22-2005 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licenses Mo/357 1 Second Ave SW; Glen Burnie, MD 21061 Carl U aneure 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician ementi 4 Car disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit Causa (Disease or that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 DHO 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Mirsing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ymo Medike 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 5 2005 Registrar

			1 - For State Registrar	State of N	Maryland / [Depar <i>Cert</i>	rtment of Fificate o	Health f Death	and M	lental H	ygiene Reg. No		34	367
	Physici /Medic		1. Decedent's Name (First, Middle, Li		ENN					2. Date of D Month October	Day	A add	ar i	ime of Death 45 A . M
	Examir		4a. Facility Name (If not institution, gi NORTHWEST HO	ve street and numbe SPITAL	•		4b. City, Town	or Location			4c.	County of D		г.
	Funeral		Social Security Number 6.	Sex 7.	Age (In yrs. last bir		If Under 1 Yea	ar If Under	24 Hrs.	8. Date of B	Def Birth (Day, Year) 9. Birthplace (State or Fore Country)			
	Director		210-44-0399	1□ M 2🂢 F	58	Yrs.	Months Day	s Hours	Min.	08/1	0/19	47 M	Country)	AND
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ation						10d. Ins	side City Limits
	• Man	ctor	MD N/A		BAL	TIMO	ORE CI	TY					1 5	Yes 2□No
	vith the	Dire	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What	Country?	
	eath v	erai	3023 WINDSOR	AVENUE 12. Was Decede	nt Ever in U.S.	13 W:		1216	igin? /Sng	noity Vac as A	US	A 14. Race - A	morican Ind	ian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event. The Medical Engities could be notified at once.	by Funeral Director	1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? X No		as Decedento Yes, specify Ci □ Yes 2∑∑ N			Rican, etc.)	10-	Black, W		
2	72 ho	eted	15. Decedent's E (Specify only highest gi		16a.	Deceder	nt's Usual Occ	upation e during mos	at of working	na	16b. Ki	ind of Busine	ss/Industry	
21215-0036	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4c	r 5+)	life. DO	NOT use reti	red)		9	DR	Y CLE	ANTNO	3
	filed Hygi other	Be Co	12TH 17. Father's Name (First, Middle, Las	")					er's Name	(First, Middl				
ylar	should be filed within and Mental Hygiene. s marked other than "umatic event, the Me.	TOE	EARL BAILE	EY				ALM	IA I	DENT				
Σ	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship TERAZINE ALLE				Address (Stre							
Baltimore,	Pages 1 nent of He ant: If itan ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci			y, crema	tion (Name of story or other p REMATO	RY		29/05		cation - City FONSV		
Balt	permit. Departi Importi any inj		21. Signature of Euneral Service Lice	nsee	Q_{\perp}	22.1	Name and Add	ress of Facili	ty HC	OWELL	FUN	ERAL	HOME	21207
			23a. July Enter the disease, or con shock, or hear failure. List only	plications that caus	ed the death. Do r	ot enter	the mode of d	BERTY	HE]	IGHTS r respiratory	AVE	, BAL		RE, MD
	Physician		shock, or hear failure. List only Immediate Cause (Final disease or condition		1tu S15 0								Interv	al Between t and Death
	/Medical Examiner		resulting in death)		s a consequence		-1000						71	,
	Examiner	<u></u>	Sequentially list conditions,		YL ALC		1510	NCGO	7		_			
/	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (01 8	s a consequence (J17.								
Ö,	cate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or a	s a consequence	of):								
58760,	cate b physic the bi	edicai	•	d										
9 XO	n certifi inding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Date of o	delivery	
P.O. Box	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ √0 9 ☐ Unknown		2 ☐ Fetal death at time of death		ctopic pregnan Other <i>(specify)</i>					Month	Day	Year
ω̈́.	s that gned b	y Pt	Part II. Other significant conditions							23e. Did	tobacco u	se contribute	to the caus	e of death?
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Sec.	e law r has be	Completed	INITAL LERCHAGE	n acec	0 ANE	7411	4,			24a. Was	psy	prior t	o completio	dings available n of cause of
a	in: Th		25. Was case referred to medical						(= "	1 ☐ Yes	ormed? 2 □ No	death		0
Division of Vital Records,	yeicia iis cert direct	To Be	examiner?	Hospital:	tient 2 ER/Out	patient	3 DOA	the man		(Check only ne 5 ☐ Res		Other (St	oecify)	
, U	ing Pt		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of In (Month, D		ime of	28c. Inj	ury at ork?	2	8d. Describe				
S	uttend death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be	e Disco of I	njury - At home, far	m street		Yes 2		8f. Location	(Street and	1 Number or	Pum l Pouto	Alumbos
<u>≥</u>	el or A s after NI Dira	Certification:	4 ☐ Homicide determined	building,	etc. (Specify)	111, 3(160)	t, lactory, office	,			wn, State)	7 Palliber or	noral mobile	Number,
	To the Hospitel or Attending Physicien: The law requires that the death certify within 24 hours atter death. Within 24 hours atter death. To the Funestal Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the bes niner: On the basis and manner:	of examination and	, death o	ccurred at the stigation, in my	time, date an opinion, dea	d place, a th occurre	nd due to the	cause(s) date and	and manner place, and d	as stated. ue to the ca	use(s)
	To th To th COMP	W	29b. Signature and title of certifier	Na Th. I	40		29c. Licer	nse number	0		29d. Date	signed (Mo	nth, Day, Ye	ear)
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_	9		30. Hame and address of person who	7 Page	AMADAN	ype, Pri	Int) No.	40/ c	SCD C	whit.	WRI	Sepa	Jourson	4133 m, mo
	Sta Registr	te ar	31. Date filed (Mosth, Day, Year)	705 32 helpis	trar's Signature	Rica	Bi							

of wis for me

Melvin B. Godman Indelible Ink. Ensure All Copies Are Legible. Please Type or Print Amend item#29d, per ME, G8 State of Man 05-07069 CTState of Maryland / Department of Health and Mental Hygiene
Amend/Unpend item#1,23a,27 perME G850 12/1/05 TT

Beg. No. 12/1/05 TT

Beg. No. 12/1/05 TT 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Melvin В. Godman, Jr. October 0 18 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7914 Bon Air Drive Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug • U6 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months ⁴1947 215-58-5813 1 **X**M 2 □ F 58 Maryland Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at Be Completed by Funeral Director Md. Baltimore Parkville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5 7914 Bon Air Drive 21234 USA Items 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 1 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No White Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Social security or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental H lent: If item 27 is marked out Melvin B. Godman, Sr. Marie Luecking 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Darlene Godman/ Wife 7914 Bon Air Dr. Parkville, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: If eny injury or QDG6. Moreland Memorial Park 10-24-05 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Fureral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Salivice Licensee 23a. Part1. Errer the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 TYes 2. No peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ es 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Scene XIX Yes 2 No 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** Josha 10/19/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 Tushu Z Curcanbera M. D. ate filed (Month, Day, Year) 32. Agistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 5 2005

Descer

Gorley, Vinginia

		1 - For State Registrar	State of Marylar	nd / De		lealth and Me Death	ental Hyg	ierze 0 0 5	34369
Physi /Med		Decedent's Name (First, Middle, Last)		Н.	GURLEY		2. Date of Deat CTOBER	23,2005 Year	3. Time of Death 4:15 А. м
Exam Funera		4a. Facility Name (If not institution, give s HOSPICE OF BALTIMO) 5. Social Security Number 6. Sex	RE GILCHRIST 7. Age (In yrs.		TO	WSON If Under 24 Hrs.	8. Date of Birth (Month, Day,		IMORE
Directo		Usual Residence of Decedent	92 ¥X 1 92	Yr		Hours Min.	01-28-1	913	TENNESSEE
i5 atter death with the Marylan or iteme 23a or 28e-f show	ector	MD. BALTIMO		ty, Iown o		WSON	1		10d. Inside City Limits 1 ☐ Yes 2 💢 💢 o
ath with I	Funeral Director	10e. Street and Number 1055 WEST JOPP	A ROAD		10f. Zip Code 21	204	11	0g. Citizen of What C	
-UU36 hours after death with the Maryland tural; or itame 23a or 28e-f ahow al Exandrar must be notithed at	Ď	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2√√No If Yes, Give Year or Dates:	.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ◯ X X to	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ofy Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify:	
2 2 3	Completed	15. Decedent's Edu (Specify only highest grade		1 (0	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	durina most of workin	g	16b. Kind of Business	
CI ZIZI filed within Hygiene. other then "	Com		4 YEARS		HOUSEW	IFE 18. Mother's Name	/Eiret Middle A	OWN HON	1E
ylanc build be f Mental H arked of	To Be		они м. н <i>а</i>	ARRIS				DAVIS	
Md 2 st lith ar lith ar treu		19a. Informant's Name/Relationship (Ty, JOHN H. GURLEY	pe, Print) (SON)		Mailing Address (Street 19 INDIAN H				
Battimore, permit. Pages 1 at Department of Hea Important: if itsm any injury or othe		20a. Method of Disposition XX Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		cemetery,	isposition (Name of crematory or other plac IS CHURCH C	EM. 10-25-	1	ONG GREEN,	,MARYLAND
Departition of the point of the		21. Signature of Funeral Service License	(R.G.RU	TH)	22. Name and Addre		HOME, IN	1050 YC C. TOWSON.	ORK ROAD MD.21204
Cat 600, Medical Examine but street be executed but street but at 11 at 12 at	al Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	Vasca juence of) 6/7/11	lar Accid		respiratory arre	est,	Approximate Interval Between Onset and Death Let (LS Years
.C. BOX 68 // The death certificate I by the ettending physis	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of de Month	elivery Day Year
	ρ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in th	ne underlying cause giv	en in Part I.	1 111		o the cause of death?
The lay	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to ned? death?	utopsy findings available completion of cause of
VIII sician s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	I FR/Outp:	atient 3 DOA Cth	er. 4 Nursing Hom		nce 6 🖫 Other (Spe	ecity) Hospice
UIVISION OT VITAI HER To the Hospitel or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ne of 28c. Injur			w injury occurred	my) [Juspi CE
UIVIS lei or Atte s after de: al Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm	, street, factory, office	21	Bf. Location (Str City or Town	reet and Number or A , State)	ural Route Number,
To the Hospitei within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1. Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, o ation and/o	death occurred at the tin or investigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the ca d at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
To th within To th	Me	29b. Signature And title of certifier	red mas		29c. Licens	e number		Oct, 23 .	
6		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Ty	pe. Print) Charles	Street	Tours	a MIN	21204
	tate	31. Date filed (Month Cay, Year) 200	37 Registrar's Signa	We Z	porte		0.000		

State of Maryland / Department of Health and Mental Hygien 2005 34370 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 21, 2005 Gladden 11:15 a M Jean B. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dulaney Towson Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 22 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 💢 F 77 Yrs. **Director** 217-24-2053 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28e-f ehow the Medical Exampler must be notified at 1 ☐ Yes 2 🙀 No Director Baltimore Timonium Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Quaker Ridge Rd. 21093 USA filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? t3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) School Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Miexsel Beehler Gladys Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Mr. James F. Gladden, Jr./ Husband 303 Quaker Ridge Rd. Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. !10**-**26-05 Timonium, Md. 21. Signature of Fune al Service Licensee ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reriangitis /Medical Due to (or as a consequence of): **Examiner** years Chromic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as signed by the attending of the deteched for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No Dm 1 Tyes 3 Probably 4 Unknown certificete has been sl rector, page 2 should I Be Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H 00 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) Katherine Asadi Do 20 E - Dimonium Rd suite MO 31. Date liled (Month, Pay, Year) OCT 2 5 2005 2. Registrar's Signature State Registra

CPM 05-07051 Bradley Giddins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Midgle, Last) 2. Date of Death **Physician** KADLEY GIDDINS October 0 13:35 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3400 block of Kenyon Avenue T. Age (In yrs. i Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number iast birthday) Birthplace (State or Foreign **Funeral** Days Hours 217.37.1303 Yrs. VENNSYLVANIA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be cotified at 1 Yes 2 No Director MD10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 PNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or iteme 1 Never Married 2 Married Baltimore, Maryland 21215-0036 20 No þ Specify: 3 Widowed 4 Divorced "neturel", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ortant: If Item 27 is marked other then injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Jermit. Pages 1 and 2 should be filed.
Depertment of Hauth and Menter important: If Item 27 is any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname IDDINS 19b. Mailing Address (Street and Number or Rural Rough Number, City or Town, 19a. Informant's Name/Relationship (Type Print) MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Gunghot Wounds /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate hes been sig page 2 should b 1 ☐ Yes 2 🕱 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of deeth?
1 ☑ Yes 2 ☐ No autopsy certificate 2□No 1 Yes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Kother (Specify) SCENE XXYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural Sul Ket 1 Yes 2 No Shot 2 Accident 1:18 3 ☐ Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3400 BLK 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3400 BLK WE, BRUTEWA EHD Sidewelk Avie Kenyon 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number OCME 29d. Date signed (Month, Day, Year) October 18, 2005 ho completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 tn UN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 2 5 2005

Rosell S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34372 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Virginia Gillard Month 20^{ay} 2005 09:45 at /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riderwood Village Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 286-26-5679 1 □ M 2 □ F 85 08#07×1920 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 TrNo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Rd. #1515 20904 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6+ Administration Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kel Osborne Iva Keene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sue Gillard/daughter 223 1/2 12th St. SE Washington DC 20003 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Chesapeake Crematory 1 ☐ Burial 2 ☐ Geremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 10-23-2005 Beltsville MD 21. Signature of Funeral Service Licensine 22. Name and Address of Facility
Rapp Funeral & Cremation Service M00382 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatice Small Cell Carcinoma 1 month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to (or as a consequence or) Due to (or as a consequence of) by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2√2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) D0043375 10-21-2005 30. Name and a sess of verion who completed cause of death (Item 23a) (Type, Print) Karen Merritt RWV Medical Center Silver Spring MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Funeral

Director

ehow.

r then "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at

filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Heelth end Mental Hygiene. ont: if item 27 is marked other then

or other treumatic event.

permit. Pages 1 and 2 s Depertment of Heelth er importent: if item 27 is any injury or other treu once.

Physician

/Medical

Examiner

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After

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or Attending Physician:

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the attending physicien

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

OCT 2 5 2003 Jenewa It foods

		For State	State of		nd / Depa		Health and	d Mental Hyg	giene 005	34373
		Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	tilicate o	Dealli	2. Date of Dea	iteg. No.	3. Time of Death
 Physicial /Medical 		Mildred M. Ger	vinski					October	Day Yea 19 2005	945 AM
Examine		4a. Facility Name (If not institution,		nber)		4b. City, Town	, or Location of D	eath	4c. County of De	eath
		Joseph Ritchie		7 4 //	1-225-4-4-3	If Under 1 Ye	Baltimore	2 Hrs. Lo. 2 (2)	N/A	
Funeral Director		212-05-9535	3. Sex 1 □ M 2 F	7. Age (in yrs. 87	. last birthday) Yrs.	Months Day		Hrs. 8. Date of Birth (Month, Day Jul. 29	Year) 9. 5	lirthplace (State or Foreign Country) [aryland
		Usual Residence of Decedent						P 421 23	, 1910 1	
show	2	10a. State 10b. County MD B.	altimore	10c. C	ity, Town or Lo					10d. Inside City Limits 1 Yes 2 No
the M	Director	10e. Street and Number	altimore			Arbu			10g. Citizen of What	
at yielitid Z I Z 13-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "naturel", or Items 23a or 28a-f show imatic event, the Medical Evanther must be notified at		5542 Carville A	venue				21227		United	•
ems 2	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	J.S. 13.	Was Decedent of Yes, specify C	of Hispanic Origin?	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, W	nerican Indian,
s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced		2 (X No		1□Yes 2⊠N		, , , , , , , , , , , , , , , , , , , ,	Specify: V	
2 hours aff	pa	15. Decedent's	Education	1105.	16a. Dece	dent's Usual Occ	cupation		16b. Kind of Busines	ss/Industry
thin 7:	Completed	(Specify only highest Elementary/Secondary (0-12) 1.2	grade completed) College (1	-4or 5+)			ne during most of ired)	working		,
led wi lygien her th					Но	omemaker				n Home
Vicino Suld be file Mental Hy Briked oth attic event) Be	17. Father's Name (First, Middle, La Paul Egger	151)					Name <i>(First, Middl</i> e, Cherine Sp:		
shout and Me	٥	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address (Stre		Rural Route Numbe		, Zip Code)
Dallimore, INaryial permit. Pages 1 and 2 should be Department of Health and Menia Importent: if item 27 is marked any injury or other traumatic events.		Joann Peach/ Da	ughter		2420	Alma Ro	ad, Lans	downe, MD	21227	
Pages 1.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	B □Removal from			sition (Name of matory or other p		Date	20c. Location - City	or Town, State
Dalltimor Department of I Mportent: if it any injury or o		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li		Вау				0-21-2005	Baltimo	
Dermi Permi Depa Impo any i		DAMOVE.	- Kau	quest				mbrose Fur		
*	1	23a. Part1. Enter the disease of conshock, or heart failure. List of	omplications that c	aused the dea						Approximate Interval Between
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/Medical Examiner		resulting in death)		or as a conse						1.02/11/1-
	ē	Sequentially list conditions, if any, leadin, to immediate	b. Due to (or as a conse	quence of):					
d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
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he death certifical the attending phy ched for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out						23d. Date of c	lelivery
death death e atte	Physician/M	in the past 12 months?	4□Pregn	irth 2 ☐ Fet ant at time of	a≀death 3□ death 5□	Ectopic pregna Other (specify)	ncy		Month	Day Year
at the diby the etache	Phys	9 Unknown	9L Unkno							
vequires that the debean signed by the should be detached	۾	Part II. Other significant condition	Mass (pro		2 4		given in Part I.			to the cause of death?
law requires I	ete	TELL MODELLA	Chip.	Work I	act, gva.	, cy		24a. Was a		autopsy findings available
The lay ate has page 2	Completed							- autop:	y prior to death'	completion of cause of
ysicien: The lav	BeC	25. Was case referred to medical examiner?					26. Place of I	1 ☐ Yes Death (Check only or		95 22 140
2 S S D	ို	1 Yes 2 No			ER/Outpatien			g Home 5 Resid		pecity Hospice
on or or or or or or or or or or or or or	tlon	27. Manner of Death 1		of Injury h, Day Year)	28b. Time of Injury	V	ork? ☑Yes 2☐No	28d. Describe h	ow injury occurred	
l or Attending after death. Director: After lin by the fune	Certification:	3 Suicide 6 Could no determin	t be 28e. Place	of Injury - At h	nome, farm, str	eet, factory, offic		28f. Location (S	treet and Number or	Rural Route Number,
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To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying (Check only one)	Physician: To the kaminer: On the ba and mann	asis of examin	owledge, death ation and/or in	n occurred at the vestigation, in m	time, date and play y opinion, death o	ace, and due to the c ccurred at the time, o	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier				-	nse number		9d. Date signed (Mo.	
		1 5-1801	NO			D	24170		October 1	9,2005
10		30. Name and address of person w	no completed caus	e of death (Ite	m 23a) (Type,	Print)	11 C+ D	3altimore	MAN	12 - 1
Stat	e	31. Date filed (Month, Day, Year)	32.	egistrar's Sign	ature	ast B	100 21 1	SAUTI/MOY	100 2	1001
Registra		OCT 2 5	2005	rever a	15. Mg	The state of the s				

Khown

Box 68760, P.0. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmore CITY 7. Age (In yrs. last birthday) & Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 0 M 2 F Days 214-34-5153 Usual Residence of Decedent Director 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 485 2 No Director 10e, Street and Number 10g. Citizen of What Country? 706 or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Eves 2 DNo 1956
If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "I eny injury or other treumatic event, Ite Naden yinjury or other treumatic event, Ite Naden Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEDT. OF AGI Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Esophageof Adeno carcinoma /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Pres 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 146 1 Yes 2 ANO 1 TYAS the Hospital or Attending Physiclen: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕶 6 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel C 1 Crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 P50693 October 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

4 and 14. PROPUES. MO SINA HUSPIAC OF BACTIMORE 2. Registrar's Signature State OCT 2 5 2005 Registrar

			1 - For State Registrar	State of Maryl		artment of F			giene ()	05	34375
	Physici		Decedent's Name (First, Middle, Last) HAROLD		GR	EENWALD		2. Date of De		2005	3. Time of Death 5:45 A M
1	/Medic Examir		4a. Facility Name (If not institution, give s 7 SLADE AVENUE #			4b. City, Town, or				y of Death	
	Funeral Director		Z10-ZZ-1034 X	M 2□F 7. Age (In 9	yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Da FEB. 17	, 1911	9. Birth	place (State or Foreign ntry) NY
	ehow	jo.	Usual Residence of Decedent 10a. State 10b. County MD BALTI		. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	vith the h	Director	10e. Street and Number		DAL	TIMORE 10f. Zip Code			10g. Citizen of	What Cou	ntry?
	death v	Funerai	7 SLADE AVENUE #	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	2120	8 ? (Specify Yes or No ruento Rican, etc.)	- 14. Ra		USA can Indian,
9036	ours after rai', or ite	Ď	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No tf Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	ueno Hican, etc.)	Specia	ick, White, fy:	WHITE
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or items 23a or 28e-f ehow event. The Madical Examinar must be notilized at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of	working	16b. Kind of E		dustry
and	2 should be fited w and Mental Hygier ie marked other the raumatic event, the	To Be C	17. Father's Name (First, Middle, Last) HARRY		GRE	ENWALD	18. Mother's SARA	Name <i>(First, Middle,</i>	Maiden Sumai	m <i>e)</i>	STERN
Mary	を書るこ		19a. Informant's Name/Relationship (Typ					or Rural Route Number			
nore,	Pages 1 ar		20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	b. Place of Dispo cemetery, crea	1.	e)	Date /23/2005	20c. Location	- City or To	own, State
Baltir	permit. Pages Depertment of importent: if i eny injury or once.		21. Signal Ore of Funerat Service License		2:	2. Name and Addres	ss ot Facility	SOL LEVII WN ROAD -	NSON & I		, INC.
7	Physician /Medical		23a. Parth. Enjer the disease of complications, of heart tailure. List only one timmediate Cause (Finat disease or condition resulting in death)	cations that caused the de cause on each line. Covernment Due to (or as a con	arten	ter the mode of dyin		diac or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Examiner	ıer	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a con							
8760,	s be executed sicien and burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
.O. Box 6	the death certificate be executed y the attending physicien and iched for use as the burial-transi	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. tf yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
rds, P	iew requires that the de as been signed by the a 2 should be detached f	þ	Part tl. Other significant conditions cont	ributing to death but not	resulting in the u	nderlying cause give	en in Part t.				ne cause of death?
Vital Records,	The ate h page	Completed						24a. Was autop perfo 1 Yes	rmed?	prior to co	psy findings available mpletion of cause of 2 \(\square\$ No
	ysician: nis certifica director, p	To Be	25. Was case referred to medical examiner?	ospital:	2 ☐ ER/Outpatier	nt 3 DOA Othe		Death Check only o	9/1	ner (Snech	v)
Division of	ling Pt		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of tnjury (Month, Day Yea.	r) 28b. Time o	t 28c. tnjury Work			now injury occur		
DIVIS	7 5 5 5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - A building, etc. (Sp	At home, tarm, str ecify)	eet, factory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	per or Rura	l Route Number,
	To the Hospital c within 24 hours at To the Funeral D completely filled in	edicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	cien: To the best of my er: On the basis of exan and manner stated.	knowledge, death nination and/or in	n occurred at the tim vestigation, in my op	e, date and pl pinion, death o	lace, and due to the occurred at the time,	cause(s) and madate and place,	anner as si and due to	ated. the cause(s)
	To the within 2 To the complete	2	29b. Signature and the of certifier	Wellind		29c. License	80a V		29d. Date signe	d (Month,	Day, Year)
	18		30. Name and address of person who com	npleted use of death (Item 23a) (Type,	Print) TWPRd	Baltu	G (M.gur	11206		
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Si		de la	•	7.0			

State of Maryland / Department of Health and Mental Hygie 0 5

3. Time of Death

7:50 PM

22,2005

29d. Date signed (Month, Day, Year) 10/24/05

	Registrar		Certificate of Death	Rag. No		
	1. Decedent's Name (First, Midd	(le, Last)		2. Date of Death		
hysician /Medical	Lavon	М.	Holcombe	October Da		
xaminer	4a. Facility Name (If not institution	on, give street and number)	4b. City, Town, or Location of Death	40		
	Stella Maris	Hospice	Towson			
neral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		

Director

or 28a-f show wat be notified at 238 "natural", or itsms

21215-0036

Maryland

Baltimore,

2005

22,

OCTOBER

LAVON HOLCOMBE

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic avent.

Physician /Medical Examiner

physicien and s the burial-transit The law requires that the death certificate be executed Box 68760 as attending i P.O. detached á signed the det Records, has certificate Vital To the Hospital or Attending Physician: ot Sic) After Division death. Director: in by

within 24 hours after To the Funeral Dire

County of Death Baltimore Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F 82 September 19, 1923 478-22-3180 Iowa Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore Dundalk 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8201 Northview Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 200 Married 1 Yes 2 No Specify Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Garfield Heathman Maggie Belle Pirie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Everet Francis Holcombe 8201 Northview Road, Dundalk, MD. 21222 husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4 Donation 27, 2005 Baltimore City, MD. 21. Signature of Fungal S rvice Lizeur ee Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, MD. 23a. Pal 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmm=date cause (Final diseas r condition resulting in death) LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: ၉ 1 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar DHMH 17 Rev 1/200 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIO MAHMOOD

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

29c. License numbe

TIMONIUM, MD 21093

		1 - For State of Maryland /	Department of Hea Certificate of De		ental Hygie	2.005	34377
	sician	1. Decedent's Name (First, Middle, Last) Daniel Patrick Harris			2. Date of Death Month October	Day 2005	3. Time of Death 1200 M
For well-	edical miner	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Loc Bel Air	ation of Death		4c. County of De	
Funer Direct		5. Social Security Number 6. Sex 7. Age (In yrs. last) 220-09-8430 X 88		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Ye June 1,	9. 8. 1917 Ma	rthplace (State or Foreign country) aryland
aryland show	5	Usual Residence of Decedent	own or Location Fallston				10d. Inside City Limits 1 ☐ Yes 2 No
ith the Marylar or 28a-f show	Director	10e. Street and Number	10f. Zip Code			. Citizen of What C	
death w	Funeral	2304 Mills Road 11. Marital Status 12. Was Decedent Ever in U.S.	210			J.S.A.	nings Indian
	d by Fun	1 Never Married 3 Married 1 Yes 2 No If Yes, Give Year or Dates: unknown	13. Was Decedent of Hispar If Yes, specify Cuban, M 1 □ Yes 2 □ No Sp	lexican, Puerto P	lican, etc.)	Black, Wh	
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours attracted thealth and Mental Hygiens. Properties of Health and Mental Hygiens. Properties of Health and Mental Hygiens.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	Sa. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)		g	b. Kind of Busines	
nd 2	Be Co	17. Father's Name (First, Middle, Last)	accountant 18.	Mother's Name	(First, Middle, Mai	accountir den Sumame)	ıg
ylar ould be Menta Menta extred	To B	Joseph Harris		Sophia S			
Z-OS re, Mar st and 2 sh of Health and item 27 is m other traum		19a. Informant's Name/Relationship (Type, Print) Dorothy L. Harris/wife	9b. Mailing Address (Street and P 2304 Mills Road	Number or Rural I, Falls	Route Number, Coton, MD 2	ity or Town, State, 21047	Zip Code)
imore Pages 1 nent of He ant: If iten ury or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of tery, crematory or other place) ir Mem. Gdns.	10/26		Location City o	
10 22 05 Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene, Important! If item 27 is marked other then "in any injury or other featmentic event, its Mental	once.	21. Signature of Funeral Service Licensee	Schimunek F 610 W. MacP	hail Ro	ad, Bel A	Air, MD 2	Inc. 21014
Physicia	an	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		ich as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
/Medic Examine		Due to (or as a consequence		untire Hea	nt failur	•	Zday.
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. Emphysema					10 425 .
956 38760, icate be executed physicien and s the burial-transit	licai		Compression Fracti	here Thors	icic, Lumb	ar Spine	
Records, P.O. Box 61 The law requires that the death certific the has been signed by the attending play 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	Nivery Day Year
Cords, P	þ	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in	Part I.	23e. Did tobaca		o the cause of death?
Tris Daniel Division of Vital Records, or Attending Physician: The law requires it after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Completed				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Niel Vital R vician: Th certificate	Be	25. Was case referred to medical examiner?		Place of Death	Check only one	10 10	2 1 10
TIS, DANIE Vision of Vital Attending Physician: clearly.	on: To		Outpatient 3 DOA Other: 4 Time of Injury at Work?		e 5 Residence	e 6 □Other (Speniury occurred	ocify)
Harris Danie Division of Vital ospital or Attending Physician: hours affer death. Internal Director: Affer this certificative in the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	M 1 ☐ Yes farm, street, factory, office	2 No 28	3f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
Di Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Ce	29a. Certifier (Clock only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examina: On the basis of examination and meaning stated.	ge, death occurred at the time, da	ate and place, ar	nd due to the cause	e(s) and manner a	s stated.
To the within 2 To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License nun			Date signed (Mon	
	2	BULGIN	D0018	1424		j · 23 · 2	
12		30. Name and address of person who impleted cause of death (Item 23a B. Parekh MD. 1908 Harford	(Type, Print)	MD. 2	1047		
100000000000000000000000000000000000000	State strar	31. Date filed (Month, Day, Year) OCT 2 5 2005	hills				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 15 34378 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician October Year 23, 2005 10:30 AM Arthur Carl Harrington /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Vrs Director 219-28-0111 72 5, 1932 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at Md. Harford Bel Air 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 204E Crocker Drive 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry othar than " Elementary/Secondary (0-12) College (1-4or 5+) boat repair/ self-employed 8 years boat repairman permit, Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked otha any injury or other traumatic avena Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Glen Harrington Vada Crigger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Harrington/wife 204E Crocker Drive, Bel Air, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gdns. 10/26/05 Aberdeen, Md. 22 Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 1 week /Medical Due to (or as a consequence of): Examiner meunonia 10 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Actinomyces 2 No 3 Probably 4 Unknown Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a Was an 1 ☐ Yes 2 No Division of Vital Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner Teath 28d. Describe how injury occurred Certification; 1 aturaf 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Me of certifier D44841 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Mac Phail Rel, Bel Arr, Med Sussman MD 31. Date filed (Month, Day, Year)
OCT 2 5 2005 32. Pajistrar's Signature State Registrar

Arthor

Harrington

State of Maryland / Department of Health and Mental Hygienen 05 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 22 2005 Alvin Franklin Harding 4:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Park 4821 Osage Street Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Y OCt. 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√2M 2□ F 217-30-4083 70 Yrs Maryland **Director** Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23e or 28a-f show the Medical Examinar must be notified at 1, Yes 2 □ No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours atter death with a Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "" any injury or other trainment. 20 Post Office Avenue 20707 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1XX Never Married 2 Married 1 ☐ Yes 2 ☐XNo White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Ø Construction Painter/Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Franklin Harding Bessie Edna Earp ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darrell McKinney/Nephew 4821 Osage Street, College Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk 10/25/2005 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Pnysician Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Liver Metastasis 5 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause full listense or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 4□Pregnant at time of death Day Month Year 5 Other (specify) P.O. been signed by the should be detached 1 Ves 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2. ANo 2 **X**No 1 Yes 1 Yes Hospitel or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Nephew's Certification: To 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 178 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Octobbe 241 145014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My HI LINEL NO 20707 ISABELLY MARTIN NO 8343 CH 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Brown St. Sports Registrar

State of Maryland / Department of Health and Mental Hygie 2e 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** HARPER 6:42 PM -AVERNE October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 28, 1960 9. Birthplace (State or Foreign Quantry) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖼 🛱 213-86-534 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director Mary and 10e. Street and Number MOTE 10f. Zip Code 10g. Citizen of What Country? 4221 Itama 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 0. Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unemp es 1 and 2 should be filed to the library of Health and Mental Hygie of Hem 27 le marked other in other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be ment of Health and Menta tent: If Item 27 le marked jury or other traumatic ev Informant's Nam elationship (Type, Print) (Aunt) 19b. Mailin. Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition Name of cemetery, crematory or other place) 710r Baltimore. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) arme 21. Signatore of Funeral Service License 22. Name and Address of Facility Joseph L. Russ 2222 W. North 7 Funeral 1 Home P.A Ave. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) +/ERNIATION Physician CEREBRAL /Medical Due to (or as a consequence of): **Examiner** One day SUBARACHNOID TEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown been si 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy certificate 1□ Yes 2 No of Vital To the Hospital or Attending Physician. within 24 hours after death.

To the Funaral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) M.D. RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE BALTIMORE, HARYLAND TOWER 21287 5 2005 . Registrar's Signature 31. Date filed (Month Day State Registrar

State of Maryland / Department of Health and Mental Hygienen 34381 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 10 Margaret Isabella Adams Henry 19 2005 14:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) 99 yrs If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11-25-1905 Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 ☐ M 2X F 579-80-6385 Yrs Director Guyana Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ehow the Medical Exactly at most be notified at MD Prince George Mitchellville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1406 Albert Dr. 20721 USA deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after Hygiene. 1XX Never Married 2 Marned 1 ☐ Yes ZONo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event pope. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henrv Mary Adams Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Collin Conrad Gray/grandson 12413 Arrow Park Ct. Ft. Washington MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State Chesapeake Crematory 10-22-2005 Beltsville MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 3 weeks /Medical Due to (or as a consequence of): Examiner Impaired Gag Reflex Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last months Due to (or as a consequence of) Examine The law requires that the death certificate be executed Dementia attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2XXNo Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peed: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Yes 2 No 1 Tes To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifical Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 plnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ER/Outpatient 3 DOA After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) D31001 10-19-2005 7D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart J. Turkewitz MD 7500 Greenway Ctr Dr. #430 Greenbelt MD 20770 31. Date filed (Month, Day, Year)

OCT 2 32. Registrar's Signature State Alexander to Species Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:50P M October 22, 2005 Ardith Joy Hood /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 241 Walgrove Rd. Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 M XXF Jan. 21, 1929 213-26-6650 76 Maryland **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "netural", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes XX No MD Reisterstown Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 241 Walgrove Rd. U.S.A. death v Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: þ XXWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 1s marked othe any injury or other treumatic event, sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas H. Hood Ida Magdelen Luthy 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Glyer Ct.; Reisterstown, MD 21136 Marta Cotterino /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 10/27/05 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown, Rd. Owings Mills, MD21117 are 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Arterioscieratic 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dua to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AHLUTO MI ath (Item 23a) (Type, Print) Philip Militello MD 6 Trumble Will Litherville, Maryland 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State Speciel 1 2005 Registrar

			1 - State of Maryland / Dep	rtificate of l	ieaith and Me Death		2005 g. No.	34383
	Physic	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Margaret Windle Hess			ctober :	21, 2005	3:00 P M
	Exami	ner	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Bel Ai	r Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6 Sex 7 Age (In vrs. last hirthday		1	8. Date of Birth	Harfor	
	Director		218-76-4989 1□ M 2 ☐ 87 Yrs.	Months Days	Hours Min.	Month, Day, 1 Aug. 27	,1918 M	rthplace (State or Foreign Jountry) aryland
	yianc how		10a. State 10b. County 10c. City, Town or L			· · · · · · · · · · · · · · · · · · ·	·	10d. Inside City Limits
	e Ma	cto	Maryland Harford Fallston	n				1 ☐ Yes 2 XNo
	ith th	Dire	10e. Street and Number	10f. Zip Code		10	g. Citizen of What C	ountry?
	ath w	rai	2407 Baldwin Mill Road	21047			JSA	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked othar than "natural", or Items 23e or 28e-1 show amportent: If item 27 is marked othar than "natural", or Items 23e or 28e-1 show amply injury or other treumetic event, the Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
5-0	72 ho	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupa	ation	16	6b. Kind of Business	:/Industry
2121	within ane. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired	during most of working ()			
	iled w tygier har ti		12 17. Father's Name (First, Middle, Last)	Homemaker	10.14 () 1.14	·	Own Home	
Maryland	should be filed withir nd Mental Hygiene. markad other than umetic evant, the Mental control of the Mental con	To Be			18. Mother's Name (_	~
Z	should ad Me mark metic	۲		nn Address /Street s	Mary and Number or Rural	Rebecca		- .
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ē,	f Head itam		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place			Oc. Location - City or	
E	Page nent c int: if		A Contract of State	Cemetery	1	_2005	Pallaton	Na
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr once.				ss of Facility Home	D 7	Fallston,	Maryland
8	897 29		stally // record	317 Cokest	oury Road.	Abinada	on, Marvla	and 21009
г		JG .	23a. Pant 1. Efter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one dause on each line.	ter the mode of dying	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) RESPIRATORY	FAIL	WRE			Onset and Death
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		e.	Sequentially list conditions, if any, leading to immediate b. INTERSTITAL Due to (or as a consequence of):	LUN	G D15	EASE		
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Ć,	tificate be executed ig physician and as the burial-transit	Examiner	resulting in death) Last Due to (or as a consequence of):					
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	rtifica ng ph as th	Medicai	IF FEMALE:					
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy			23d. Date of de	*
	the dea by the at	/sici		Other (specify)			Month	Day Year
P.0	that the ed by detac		Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause give	en in Part I	23e Did tobar	cco use contribute tr	the cause of death?
ds,	uires that signed t	d by	HYPERTENSION	ndonying oddoo givo	on were carrier.			robably 4 AUnknown
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of Vital	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA Othe)r		ce 6 ☐Other (Spe	cify)
0	ding Physician: The h. h. After this certificate ha funeral director, page		27. Manner of Death 1 Alatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of (Month, Day Year)	f 28c. Injury Work		d. Describe how		
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Division	or Att	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
	pital		One Continue of Continue Delivery					
	To the Hospital or Attending Is within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deat a control of the con	n occurred at the time vestigation, in my op	e, date and place, and inion, death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier	29c. License	number	29d.	. Date signed (Mont	h, Day, Year)
1	201		30. Name and address of person who completed cause of death (Item 23a) (Type,	D &	502+	00	राजिस रे	2 2005
0	<u> </u>		VIJAY M. ABHYAN RAR INOR		JUE BE	L AIR	MD &	1014
	Sta		31. Date filed (Month, Day, Year) 32. registrar's Signature	made 1		- /		
	Regist	ar	OCT 2 5 2005					
DIE	MU 17 Day 1/2	004						

M445345

Hess, Margaret

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 3: 350 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 21, 2005 Octoba **Physician** VICKY HOWELL /Medical 4b, City, 4c. County of Death Facility Name (If not institution give street and number) Examiner NIA Age (In yrs. last birthday, if Under 24 Hrs 8. Date of Birth (Month, Day, Year 01- 24- 1961 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Davs Hours Months 1 □ M 2 1 F ALABAMA 220.74.8672 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f show 1 Nes 2 No NA BALTIMORE MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code CLITHBERT 21215 238 AVENUE USA 5346 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 11. Marital Status 1 Never Married 200 Married 5 1 ☐ Yes 2 X No Specify: Specify: BLACK If Yes, Give Year or Dates: δ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Flementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOME MAKER NA 12/14 GRADE permit. Pages 1 and 2 should be file.

Department of Health and Mania Hygh Important: If tem 27 is marked ony injury or other 27 is marked one. or other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be OGLETREE CATHERINE EARL JASPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OM NUOTSUADINA RANDAUSTOWN MD HUSBAND CERRY HOWELL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MOODLAWN 10.28.05 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal ve of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATI PIKE, BALTO. MO 21229 Jaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 980 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes 1 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item Registrar's Signature State 2005 2 5 Registrar

Physician

/Medical

Examiner

Funeral

Director

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2 should be filed within 7 and Mental Hygiene.

permit. Pages 1 and 2 st Depertment of Health and Important: If Item 27 is n eny Injury or other treum 2002.

Baltimore,

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ox 68760, A	h certificate be executed	ending physician and use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygigar 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1:37 AM M NORMAN NATHAN HOCHBERG October 20 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAL Hospital of Baltimore City Baltimore N/A If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAY 24, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F 216-16-5094 82 MD Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 WHISPERWOOD COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **HOCHBERG** IDEL **JENNY** RAPPAPORT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERIE HOCHBERG / WIFE 4 WHISPERWOOD COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) PARK 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) OHEB SHALOM MEMORIAL 10/23/2005 REISTERSTOWN, MD 21. Stylandry Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration T Due to (or as a consequence of): Pneumonia day disease or condition resulting in death) Sequentially list conditions, Cua to for as a consequence of: flan, leading to in needs cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 Yes 2 1 No 3 Probably 4 Unknown History of Poliomyelitis Hypertensian 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 12 No Hairy Cell Leukemia 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

page 2 should within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O.

Hospital or Attending

the e

State Registra

Samuel Yoselzuitz, MD 31. Date filed (Month, Day, Year) 2 5 2005

Son Yoselevitz, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

actober 20, 2005

	1	For State Registrar	S	tate of	Marylan		rtment c			lental Hyg	iene _{eg. No.} 0	05	343	86
Physician		1. Decedent's Name (First, Middle								2. Date of Dear Month	Day	Year	3. Time of 5 25	
/Medica	1 -	JEANNE ta. Facility Name (If not institution		at and num	her)	HA	CKERMAN		tion of Death	October	30 4c. Cou	2005 Inty of Death		A M
Examine	r	Sinai Hospital	-	Back				more				,	N/A	
Funeral Director		5. Social Security Number 216-18-4826	6. Sex 1 ☐ M	2 X F	. Age (In yrs. I	_		ear If Ur lays Hou	nder 24 Hrs. urs Min.	8. Date of Birth MAY . 3, 1	921	9. Birth Cou	place (State o	r Foreign
and ow	-	Usual Residence of Decedent 10a. State 10b. County			10c. City	y, Town or Lo	cation					T	10d. Inside Ci	ty Limits
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e 23a	20	3601 FORDS LA			lent Ever in U.	S 13 V	Was Decedent		1215	ecify Yes or No-	14.	Race - Amer	USA ican Indian.	
ire, Marylatia ZIZIO-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, its Modical Examinatic such Discours	by Funeral	Marital Status Never Married 2 Mar Midowed 4 □ Divorced	ried	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No		f Yes, specify		xican, Puerto	ecify Yes or No- Rican, etc.)		Black, White ecify:		
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		4	- State of Maryland / Department - State of Maryland / Department - State of Maryland / Department - For Maryland	entor Health and Mate of Death	ental Hygier	2005	34387
	Mari	40	Nagistrar Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
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10	Examin	19	4a. Fecility Name (If not institution, give street and number) 4b. C	ity, Town, or Location of Death		4c. County of Death	1
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-	- Funeral Director		1XI M 2 T F G G Vrs Month		05/21/1	939 DE	nplace (State or Foreign untry) NNSYLVANIA
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Baltimore,	permit. Page Department Important: If any Injury or once.		21. Signature of Juneral Service Licensee 22. Name	e and Address of Facility HC LIBERTY HEI	WELL FUI		ME 21207 MORE, MD
44	*		23a. Phys. 5 for the disease, or complications that caused the death. Do not enter the ship in the art failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
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sio	r Attendii er death. rector: A by the fu	cati	2 Accident investigation	1 Yes 2 No	204	A	-1.C- 1-16
Division	or At ifter d Direct in by	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	ctory, office	28f. Location (Stree City or Town, S		rai Houte Number,
u	spital		29a. Certifier 1 € Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place,	and due to the caus	e(s) and manner as	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Madical Examiner: On the basis of examination and/or investigations)				
	To th withir To th comp	×	29b. Signature and title of certifier	29c. License number		Date signed (Monti	
			· ////	0-18542	EX	JUBER	18, 2005
	10		30. Na and ad ress of person who completed cause of death (Item 23a) (Type, Print)	INE CENTER	L WAC	DONE, N	18, 2005 Nd. ZELOZ
	St Regist	ate rar	30, Na and ad ress of person who completed cause of death (item 23a) (Type, Print) PUISOTS (M.A). 2070 CV 2 31. Date filed (Month, Day, Year) OCT 2 5 2005 32. Megistrar's Signature	v ·		7	
	TO SEC AS	L.	Later Land				

Steven	ı Gary	Jo	hnson 1- State Registrar		State of M	aryland / [Department of Certificate of	f Health and of Death	Mental Hy	/giene	000	34388
(3)	Physic		Decedent's Name (First,		Sary Jo	hngon			2. Date of D	eath	ž, 200 5	3. Time of Deat
	/Medi Exami		4a. Facility Name (If not ins				4b. City, Town	n, or Location of Dea			. County of Death	
	Exami	Hel	Rt 65N @ I 7				Hagers			Ţ	Washingt	on
	Funeral		5. Social Security Number	6. Sex		ge (In yrs. last bil		ar If Under 24 Hrs		irth	9. Birth	hplace (State or For
	Director		224-58-162	2 103	M 2□F	61	Yrs. Months Da	ys Hours Will	MAY 30	19	44 Wash	ington. D
	DC *		Usual Residence of Deced			10c. City, Tow	n or Location					10d. Inside City Lin
-	eho.	2				Toc. City, Tow						1 ☐ Yes 2 🔀
	28a-1	Director	Maryland Mo	ntgomer	У			nsington		10- 03	tizen of What Cou	
	with	늅		٠,	D 1	1 77 .	10f. Zip Cod					unitry :
ŧ	na 23	erai	3127-12 Uni		7 BOULEV 2. Was Decedent			0895 of Hispanic Origin? (Specify Ves or N		USA 14. Race · Amer	rican Indian
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. kerked other than "naturel", or Itama 23a or 28a-f ehow tatic event, the Modical Examinar must be notified at	by Funeral	1 □ Never Married 2[3 □ Widowed 4\(\frac{1}{2}\) Driv	Married	Armed Forces 1 Yes 2 Y If Yes, Give Year or Dates:	?	If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puel No <i>Specify:</i>	rto Rican, etc.)		Black, White Specify:	
9	2 hou		15. De	cedent's Educ	ation	16a	Decedent's Usual Oc	cupation		16b. K	ind of Business/l	
215	Mad A	Completed	(Specify only Elementary/Secondary (highest grade	Completed) College (1-4or	5+)	(Give kind of work do life. DO NOT use re	ine during most of wo tired)	orking		Dani I di o.	
21;	giene giene	E O	12	, , , ,	oonogo († 10.	31,	Construct	ion		1	Building	,
P F	be filed ital Hygir id other event, III	Be	17. Father's Name (First, M	liddle, Last)				18. Mother's Na	me (First, Middl	e, Maiden	Sumame)	
<u>a</u>	should be ind Mental i marked umatic ev	10E	Clifford F	'. Johns	son			Rut	h Helen	Mill	.er	
<u>a</u>	E E		19a. Informant's Name/Re				. Mailing Address (Str					
	Health at tem 27 litem 128 litem		Clifford F.	Johnsor	ı, Jr./Bı	and the second s				+		
altimore,	of H of H or oth		20a. Method of Disposition 1 ☐ Burial 2 ② Crem	ation 3 □Re	moval from State	20b. Place o cemete	f Disposition (Name of ry, crematory or other	place)	Date	20c. Lo	ocation - City or 1	Fown, State
Ë,	permit. Pages I Department of H Important: If Ite any injury or ot once.		4 □Donation 5 □ Of	her (Specify)		Metro	Crematory	, Inc. 10/	21/05	Ba1	timore,	MD
alt	permit. Departr Imports eny inju		21. Signature of Funeral S				22. Name and Ad	dress of Facility	of MD	Inc		
Δ.	g ⊽ E ≥ 9		Edward A.	Gregø	rchik			n Society erick Road			MD 2122	
	Physician /Medical		23a. Part1. Enter the diser shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ase, or complice. List only one	cause on each i	ine. Cation a consequence		w to collect		3	oma	Approximate Interval Between Onset and Death
	Examiner	1	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	, b.	Due to (or as	a consequence	of):					
X	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events	1								
ó	an ar rial-ti		resulting in death) Last		Due to (or as	a consequence	of):					
8760,	cate be physici the bu	dicai		d.								
89	Physician: The law requires that the death certilicate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Med	IF FEMALE:							-		
Box	eath certific attending p I for use as	an/	23b. Was decedent pregna in the past 12 months	al It		2 Fetal death	3 □Ectopic pregna	incy			23d. Date of deliver Month	very Day Year
. E	e dea the at hed fo	Sici	1 Yes 2 No		4☐Pregnant a 9☐Unknown	t time of death	5 Other (specify)			WOITH	Day 19a1
P.0	res that the de signed by the a be detached to	Physician/Me		anditions and	abution to double t				22a Did	1-6		Abo and death
<u>v</u>	res fr engis be d	ğ	Part II. Other significant c	23e. Did tobacco use contribute to the cause of death? 1 Test 2 Sto 3 Probably 4 Unknown								
orc	w requir been si should	Completed				_			1	Yes 2,	7 3 Pro	bably 4 Unkno
ec .	law lasb	ple							24a. Wa auto	DDSV	24b. Were aut	topsy findings availa completion of cause
<u> </u>	the page	Sol								ormed? 2 ☐ No	death?	
/ita	sician: The is certificate ha irector, page 2	Be	25. Was case referred to n examiner?						ath (Check only	one)		
£	Physician: r this certifice ral director, p	ို	1 ∑XYes 2 ☐ No	Ho	ospital: 1 Inpati		TOTALISTIC SUIDON				6 x Other (Spec	#Scene
U.	ing P	on:	27. Manner of Death	Pending	28a. Date of Inju (Month, Da			njury at Work?	28d. Describe	how inju	ry occurred	
sio	Attending in death. ector: After by the funer	cati	E	nvestigation Could not be				I ☐ Yes 2 ☐ No				
<u>–</u>	는 전 # c	Certification:		determined	28e. Place of In building, e	jury · At home, fa tc. <i>(Specify)</i>	ırm, street, factory, offi	ce		(Street and own, State		ral Route Number,
	To the Hospital within 24 hours and the Funeral completely filled	Medical	29a. Certifier 1 Ce (Check only 2 Me	ertifying Physi edical Examin	cian: To the best er: On the basis of and manner si	of examination ar	e, death occurred at the od/or investigation, in m	e time, date and plac ny opinion, death occ	e, and due to the urred at the time	cause(s) , date and) and manner as d place, and due	stated. to the cause(s)
_ :	vithin rothin compl	Me	29b. Signature and the of	certifie	111		29c. Lic	ense number		29d. Da	te signed (Month	n, Day, Year)
	->-0		*X1/	12V	X IV		OCI	√TE.		Octo	ober 17,	2005
	M		30. Name and address of p	erson who con	ppleted cause of	death (Item 23a)				OCL	DUCK 1/,	2007
	")		5,7	1106			Street, Bal	ltimore, M	Maryland	2120	01	
F. 100	St	ate	31. Date filed (Month, Day,	Year)	32. Regist	rar's Signature						
	Regist		OC	T 2 5 21	005	A. A	(July)					
DHM	IH 17 Rev 1/	2001			· Committee of the comm	The State of the S	-					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiere 0 0 5 34389 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 645PM JONES 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Wonths | Days | Hours | Afficiency | BALTIMORE BALTIMORE 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** VIKGINIA Months Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is markad other than "natural", or itams 23a or 28a-f shov othar traumatic evant, the Madical Exambrat must be notified at BALTIMORE 1 Yes 2 No Director MU 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WEDERE AVE APT312 USA Funeral Was Decedent Ever in U.S. Armed Forces 7 1 ☐ Yes 2 7 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "I any injury or other traumetic event, the New any injury or other traumetic event, the New ondary (0-12) College (1-4or 5+) TTENDANT. 17. Father's Name 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1651 E. BELVEDERE AVE APT312 BALTOMO 21239 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 10-22-05 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN GREEN 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician negastates /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Hypertension Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Disease Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 dunknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Hatural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) CUNO D31464 MD 10/21/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore MD 21201 ENTAN ST Finte 305 821 3HM1 N. 31. Date filed (Month, Day, Year) OCT 2 5 2005 32. Registrar's Signature Registrar

CPM 05-06769 Kimberly Jungo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erly Jur	ngo	1- For Unpend Item 2	State of Maryla 23a,27,28a f	nd/Depa per me <i>Ce</i>	edment of H G849 file rtificate of L	ealth and 9-05 tas Death	Mental Hygi	ene 005	34390		
Dhyoi	aina	Decedent's Name (First, Middle, Last)			 -		2. Date of Death Month	Day Yes	3. Time of Death		
Physi /Med		Kimberly Jungo					October	05, 200			
Exam	iner	4a. Facility Name (If not institution, give			4b. City, Town, or		h	4c. County of D			
		Laurel Regional Ho		s. last birthday)	Laur		8. Date of Birth	Prince (
Funera Directo			M 2₽F 45	Yrs.	Months Days	Hours Min.	(Month, Day,		Birthplace (State or Foreign Country) alifornia		
D		Usual Residence of Decedent					000 20,	1037			
arylar ehow	_	10a. State 10b. County	-	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X☐ No		
he M	Director	MD Prince	George's	Bur	10f. Zip Code		140				
with t	급	3648 Turbridge	Drive	10	10g. Citizen of What Country? USA						
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland lial Hygiene. Id other then "natural", or items 23a or 28a-f ehow event, ite Mudicul Explicit et must be indiffied at	Funeral		12. Was Decedent Ever in		Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14. Race - A	merican Indian,		
or Ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, W	/hite, etc.		
ours :	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: V	white		
within 72 hours after sens. then "neturel", or its	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of	turina most of wo.	rking	6b. Kind of Busine	ss/Industry		
withir then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		DO NOT use retired, ousewife)		orm ha			
Hygin Hygin		17. Father's Name (First, Middle, Last)	4		ousewire	18. Mother's Nar	ne (First, Middle, M	OWN ho	unk		
yland ZIZI ould be filed within Mental Hygiene. sarked other then satic event, Italy	To Be	Claude Doolen									
sh of a series		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ural Route Number,	City or Town, State	e, Zip Code)		
2 5572		Raymond Jungo/spo				e Drive	Burtonsvi	lle, MD	20866		
Ses 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, cres	sition (Name of matory or other place	9)	Date 26	c. Location - City	or Town, State		
Pag tment tant:		4 □ Donation 5 ☑ Other (Specify)	in state			i					
Daltimore, permit. Pages 1 en Department of Heal Important: If Item 2 eny injury or other		21. Signature of Funeral Service Licens Ronald S	Jade Directo	or Si	Name and Address tate Anato altimore,	omy Boar MD 212	d 655 W. 3	Baltimor	e Street		
		23a. Part 1 Enter the disease, or compl shock, or heart failure. 'List only or	ne cause on each line.						Approximate Interval Between		
Pnysicial	_	Immediate Cause (Final disease or condition	Carisoprodo Fatty Metam	l and l orphosi	thanol In s of the	itoxicat: Liver	ion Compli	cating	Onset and Death		
/Medica Examine	_	resulting in death)	Due to (or as a conse	equence of):							
	ē	Sequentially list conditions	Due to (or as a conse	equence of):							
uted Insit	٦Ě	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		.423.133 31).							
exection and ital-tra	Examin	resulting in death) Last Due to (or as a consequence of):									
. BOX DA/DU, death certificate be executed e ettending physicien and ad for use as the buriat-transit	dical		t								
rtifica ng ph	Medi	IF FEMALE:									
BOX O	Physician/Me	35. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of delivery Month Day Y			
the degraph of the edring of t	sici	1 ☐ Yes 2 ☐ No 9 Ø Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)			Month Day Year			
w requires that the de been signed by the should be deteched		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.						bacco use contribute to the cause of death?			
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ecords law requires as been sign	lete						24a. Was an	24h Wara	autopsy findings available		
a o c a	Completed						autopsy performe	d? prior death	to completion of cause of		
VICAL F sician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	100 Yes 2	□No 1XY	es 2□ No		
ysici nysici nis ce	To B	examiner? 1 X Yes 2 □ No	lospital: 1 ☐ Inpatient 2 0	XER/Outpatier	t 3 DOA Othe	ar-	lome 5 ☐ Residen	ce 6 Other (S	pecify)		
ng Phy Ifter this		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury Fo(1901), Day Year)	Found	28c. Injury Work	at ?	28d. Describe how	injury occurred	unk		
STO STO Tendi For: A	catl	2 Accident investigation	10-5-05	12:30	A M 101	res 2 No					
LIVISION I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 🛱 Could not be 4 ☐ Homicide	28e. Place of Injury - At I building, etc. (Spec	eify)	eet, factory, office		City or Town,	State) 3648	Rural Route Number, Turbridge Dr.		
pital purs a purs a perel I	a Ce	29a Certifier 1 ☐ Certifying Phys	Found at ho		a occurred at the time	and place	Burtonsvi	lle, Md			
Hos 124 h	ledica	(Check only 2X Medical Examinations)	ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my op	pinion, death occu	rred at the time, dat	e and place, and c	as stated. due to the cause(s)		
To the Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific, completely filled in by the funeral director,	Me	29b. Signature and title of certifier	000		29c. License	number	290	I. Date signed (Mo	onth, Day, Year)		
		Hat Ilam.	ca-Koll.	w	0.	C.M.E.	0c	tober 06	, 2005		
		30/ Name and address of person who co	impleted cause of death (Ite			200+ D-1	timese M	owrlas I	21.201		
		TARICIA AFONICA	- TOLLAK M!	11		eet, Bal	timore, M	aryland	Z1ZUI		
S Regis	itate strar	31. Date filed (Month, Day, Year) OCT 2 5 200	Registrar's Sign	nature Apr	was)						

	1 - For State Registrar	State of Marylar		artment of F tificate of a			ene 005	34391	
Physician /Medical	1. Decedent's Name (First, Middle, La Elizabet	h M.	Kiefr	ner		2. Date of Death Month October	Day Year	3. Time of Death 10:00A M	
Examiner	4a. Facility Name (If not institution, gi 5826 Farmview Av	enue		0ver1			4c. County of Death Baltimore		
Funeral Director		Sex 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Augus t	30,1927 Ma	lace (State or Foreig itry) ryland	
Maryland Ind	10a. State 10b. County Maryland Baltim		ity, Town or Lo				1	0d. Inside City Limits	
uffer death with the Mar r Items 23a or 28a-f si direr: wat be notified Funeral Director	10e. Street and Number 5826 Farmview A	venue		10f. Zip Code 21	206	10	og. Citizen of What Cour	ntry?	
by	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H i Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh		
ygiene. Net than "neture net than "neture nt, if a M. Jie Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired ME Maker	ation during most of worki 1)	ing	6b. Kind of Business/In	dustry	
and Mental Hygiene and Mental Hygiene is marked other than sumetic event, Item	17. Father's Name (First, Middle, Las	Adams			18. Mother's Name Tek 1	,	^{laiden Sumame)} M. Witko	sski	
Health and Health and Structure treume	19a. Informant's Name/Relationship Mr. Bruce W. Kie	fner - Son	9417	Dana Vis	sta Road	Baltimo	City or Town, State, Zip Ore, Maryla	nd 21236	
Department of He importent: If iter any Injury or oth ance.	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 (Removal from State	Garden:	sition (Name of natory or other place S Of Fait	th Oct.	26, 200		e, MD	
Department Importent: Importent: Importent: I eny Injury o	21. Signature of Funeral Service Lice	artook of	Le		Ruck, In	c. 5305	Maryland 2 Harford Ro	21214 i.	
iysician Medical kaminer	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	th. Do not ente	er the mode of dyin	g, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death	
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d by the attending pretached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ √10 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ny Day Year	
been signed by the should be detached feed by Physic	Part II. Other significant conditions	contributing to death but not re	sulting in the un	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	e cause of death? abiy 4 ∐Unknown	
ate has page 2						24a. Was an autopsy perform	prior to cor	psy findings available npletion of cause of 2 No	
hysicien: this certification I director	25. Was case referred to medical examiner? 1								
tel or Attending P rs after death. el Director: After i ed in by the funera Certification;	3 Suicide 6 Could not 4 Homicide determined		nome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,	
To the Hospitel or Atte within 24 hours after de To the Funerel Directs completely filled in by it Medical Certific	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as st te and place, and due to	ated. the cause(s)	
To the comp	29b. Signature and title of certifier	afort w		29c. License	546		d. Date signed (Month,		
	30. Name and address of person who	or pleyed cause of death (Ite	m 23a) (Type.	Print)	h0	1220			
State	560 Loch RG 31. Date filed (Month, Day, Year)	32. Registrar's Sign	Som	move,	Mag 2	-1239			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 23, Janet Shirlev 2005 2:25 p Kolle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Aug. 9, 1 Towson Baltimore 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 √ F 75 Yrs. Director 220-26-6815 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h Count 10d. Inside City Limits 28e-f ehow traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 708 Camberly Circle Apt. B6 21 204 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "nature!", or item eny injury or other traumatic event, the Mouthant appre. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White þ 3 ☐XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Church Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be Louis Schuster Amelia Hurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott A. Hisey / Son 26 Sugar Tree Place Cockeysville, Md. 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Hillton Service Corp. 10/27/05 4 ☐ Donation 5 ☐ Other (Specify) Towson,Maryland 21. Signature of Funeral Service Mensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only oper cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) weeks plon /Medical to (or as a consequence of): Examiner Sequentially list conditions, it any, learning to minimulate cause. Enter Underlying Cause (Disease or injury Examiner Due to for se's nonevouence off attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Mo 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other signi cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Zunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA 27. Man er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Natural Accident 1 ☐ Yes 2 ☐ No hours after death. investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

P57303 29d. Date signed (Month, Day, Year) DUTOBER 24 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST POWSON MD 420 6601 N. CHANCES W 32. Registrar's Signature State Registrar

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Holle, Unet Oubber 33, 2005

William Kirkpatrick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-07077 State of Maryland / Department of Health and Mental Hygiene 34393 1 - For State Registrar crn Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day October 0 18 2005 10:30 /Medical (If not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner N/AJohns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age_(In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 1**X**M 2□ F Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 es 2 No Director and Number 10g. Citizen of What Country? 10f. Zip Code or iteme 23a Funerai 13. Was Deceden nt of Hispanic Or t of Hispanic Origin? (Specify Yes or No-Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian Black 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry is 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame Be 19a. Informant's Name/Relationship Type, Print) 114b. Mailing Address (Street and Number or Rural Route Nu 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State ō <u>=</u> United the second state of the second state of the second ŏ permit. Page Department of Important: if eny injury or 21. Signature of Funeral Service Licensee 10 MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Wounds **Physician** burghets /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) physicien Box 68760 Physician/Medical as the t IF FEMALE: use : 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ₫ Month Day 4□Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 Ayes 2 No 1 ØYes 2 □ No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 No 2 DOA 3 DOA 2 1 Inpatient After this filled in by tha funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending aftar death. 1 Yes 2 No Shot 10/18/05 2 Accident investigation July let 10:01 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) (700 BUK N. 1874. St. Roll & Mare P. D. within 24 hours aftar To the Funeral Direct 4 Homicide THOOBEKN BROOM 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely **XXMedical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME October 19, 2005 WA 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Mortin Day, gears State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 State Regist Amend Item #26 Per Phy C484 10/25/169ten Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KURYK DOROTHY OCTOBER 19, 2005 4:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4730 ATRIUM COURT #170 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 23, 1925 OWINGS MILLS BALTIMORE 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 213-20-2572 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Itema 23a or 28a-f ehow The Medical Extrainer must be notified at 1 ☐ Yes 2 No Funeral Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4730 ATRIUM COURT #170 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Prierto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE ۵ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME of Heelth and Mental Hyger If Item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be ISAAC WARANCH SILVERSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOEL KATZ / 1111 JENNIPER LANE - ANNAPOLIS, MD 21403 SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 10/21/2005 WOODLAWN, MD 21. Sign of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZHEIMERS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical .he 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3. Ectopic pregnancy Month Day Year 4☐Pregnant at time of death the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2□No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outoatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 5 Pending investigation after death.
I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the ! 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) well

Registrar

State

32. Registrar's Signature

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H rtificate of L	lealth and M Death		ene 005	34395		
	Dhuaisi	-	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death		
	Physici /Medi		Katherine F. Ko	bin					18, 2005	10:38PM		
1	Examir	er	4a. Facility Name (If not institution, give)	4b. City, Town, or	Location of Death		4c. County of Dear	h		
		*	Levindale Nursi				timore					
	Funeral Director		5. Social Security Number 6. Se	x 7. A □M 2☐F 7. A	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	hplace (State or Foreign untry)		
			Usual Residence of Decedent	Λ	89			Mar 12,	1916 Ma	ryland		
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	B-fsl	tor	MD		Baltimo	re				1√2 Yes 2 □ No		
	th the	Director	10e. Street and Number		-1	10f. Zip Code		100	. Citizen of What Co	untry?		
	23a		2434 W. Belveder	e Avenue			21215		USA			
	ems	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame Black, Whit			
36	filed within 72 hours after death with the Maryland Hygiene. yther then "naturel", or Items 23a or 28a-f show ant, the Medical Exament must be trofified at		1 Never Married 2 Married	1 ☐ Yes 2 X If Yes, Give	No	1 ☐ Yes 21 ☑ No	Specify:		Specify: wh			
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Maryland	Henfa Henfa Ked	ToB	William J. Reid				Estell	e C. Duff				
ary	shot and N s ma	_	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Street a	and Number or Rura	l Route Number, C	City or Town, State, 2	lip Code)		
Σ	and 2 salth a n 27 i		Nathan Kobin/son		250	Pendletor	n Court A	rnold, MD	21012			
altimore,	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place		ate 20	c. Location - City or	Town, State		
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Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, I'm Medical Exams are Lintel for Indillied at Once.		21. Signature of Funeral rvice Licens	Wade, Dir	ector St	Name and Addrestate Anato Altimore,	omy Board		Baltimore	Street		
J.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line.									
F	Physician		Immediate Cause (Final disease or condition		Interval Between Onset and Death							
	/Medical		resulting in death)	a. CORONARY ARTERY DISEASE Due to (or as a consequence of):								
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	and and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of);							
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Вох	that the death certifing ed by the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant			23d. Date of deli	verv					
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<u>о</u> .	at the by th	hys	9 🗆 Unknown	9 Unknown								
s,	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by	Part II. Other significant conditions co.		out not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac	Did tobacco use contribute to the cause of death?			
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e C	has be	ple	ATRIAL FIBRIL	LATION				24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of		
<u>=</u>		Completed						performed 1 ☐ Yes 2 🖸	1? death?			
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	la anital:			26. Place of Death					
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LO	ding Phys h. After this funeral di	tion	1 Natural 5 Pending	28a. Date of Inju (Month, Da	ary Year) 28b. Time of Injury	28c. Injury Work'	at ? es 2 □ No	8d. Describe how i	injury occurred			
Division	I or Attenc after death Director: in by the	fica	3 Suicide 6 Could not be	28e. Place of In	jury - At home, farm, stre			28f. Location (Street and Number or Rural Route Number.				
2	after after Dire	Certification;	4 Homicide determined	building, e	c. (Specify)	out radiory, onloo		City or Town, S	itate)	ar ricate rearriber,		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier 1 Cortifying Phy (Check only one)	ner: On the basis of	of my knowledge, death	occurred at the time restigation, in my opi	a, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated.		
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner st	ated.	29c. License			Date signed (Month)			
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		-	30. Name and address of person who co				63327	//	0/19/03)		
			GIZAW WOLDEHI				Baltimo	re mi	21215			
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	Registra	ar	OCT 2 5 2005	Mercus	ar's Signature	(L)						

Kobin, Katherine

		1 - For State Registrar	State of Marylan	d / Departmen Certificat	t of Health and e of Death		en 2 005	34396
Physi /Med		1. Decedent's Name (First, Middle, Last)	LEWEN	BERG		2. Date of Death Month	Day Year 06 2005	3. Time of Death
Exam Funera Directo	iner	5. Social Security Number 6. Sex	MAN Ai MAN Ai M 2XF 7. Age (In yrs.	IE. BI	Town, or Location of Deal Typear If Under 24 Hrs Days Hours Min	8. Date of Birth	4c. County of Death A 9. Birthplac Country	ce (State or Foreign
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th with the 23a or 286	Funeral Director	10e. Street and Number 2900 BOARN	AN AUE.	10f. Zip		100	Citizen of What Country	1?
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within 72 hours all ene. then "naturel", or the Medical Exert	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) Coflege (1-4or 5+)	16a. Decedent's Usur (Give kind of wo life. DO NOT u	al Occupation rk done during most of wo se retired) TRESS	erking 16	Sb. Kind of Business/Indus	stry
tha killed be filed at a their section.	To Be Co	17. Father's Name (First, Middle, Last) William	CLAY	SZAPOL		me (First, Middle, Ma		2_
re, Maryle s 1 and 2 should f Health and Mer frem 27 Is marke other traumatic		20a. Method of Disposition	ON SOC SEC 206. P	19b. Mailing Address O D O Place of Disposition (Nare)	ALVERT ST	-#300 L	City or Town, State, Zip Co BHLTO HD. Oc. Location - City or Town	21201
Baltimo permit. Pages Department of Importent: If I eny Injury or		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	BA	TV VIEW	Address of Facility	SHANDA F	MITIMORE	MD.
Physiciar /Medica	1	23a. Part1. Enter the disease or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	monia		c or respiratory arres	fr	pproximate hterval Between chset and Death
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death certii death certii e attending id for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree of the second second 10 □ Unknown	I death 3 □Ectopic pr			23d. Date of delivery Month Da	ay Year
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nding Phy ath. r: After this	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No			28d. Describe how injury occurred		
To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege	Certification:	3 Suicide 6 Could not be determined	City or Town,	treet and Number or Rural Route Number, n, State)				
the Hasy hin 24 ho the Fune mpletely fi	Medical	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	tion and/or investigation	, in my opinion, death occi	urred at the time, date	and place, and due to th	e cause(s)
T wit		29b. Signature and title of certifler	serai M)	D 2674	8 290	Date signed (Month, Da	v. rear)
	tate	30. Name and address of person who con An L 31. Date filed (Month, Day, Year)	npleted cause of death (Item 3 FM L Registrar's Signa	4419	FALLS	RO	BALTO	MO
Regis		OCT 2 5 2005		Booke				~10(1)

State of Maryland / Department of Health and Mental Hygien 0.5Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** DEBORAH B. 2005 Luck *3:3*0 10.15. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA STREET BALTIMORE DANA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country). **Funeral** 1 ☐ M 2 🛇 F 135.46.4186 53 NJ 08.16.1952 Director Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Depertment of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show says injury or other traumatic event, it a Medical Event are must be unfilled at once. 1 Yes 2 No Director NA BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4317 DANA STREET 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HEALTH CARE 1214 GRADE YRS NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NHOD BOWERS CATHERINE 2 CHAMBERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANEEN MCLEAN PIKESVILLE. (FRIEND) PEACH TREE CT. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 □ Cremation 3 □ Removal from State ARBUTUS 10.21.05 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) VAUGUN C. GREENE FUNERAL SERVICE 15151 BALD. NAT. PIKE, BALIO. MD 21229 21. Signature of Funeral Service Licenses Wangh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificete hes b irector, page 2 s autopsy performed 1 Yes 2 No 24 hours efter death.
• Funers! Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the th th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/18/2005 D40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Baltinar 21234 Rischen 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene 0 5 34398 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Muska October 23, 2005 1:43 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 White Ash Court Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 20, 10 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 47 215-48-3830 Yrs. Director 1958 Maryland Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Mudical Examiner must be notified at Director Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 White Ash Court 21220 U.S.A. or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Μ. Muska. Jr. Sojak Julia Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 White Ash Ct., Baltimore, MD 21220 Mrs. Lynn Muska (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If iter
eny injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 XOther (Specify) Entombment Holly Hill Mausoleum 10/26/05 Baltimore, Maryland 21. Signatu Service See 22. Name and Address of Facility Schimunek Funeral Homes 9 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Methstatic Melanome disease or condition resulting in death) 71 Morans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performe 2 No 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check onl one) examiner? Cther: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 7 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Natural 5 Pending after death. death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 038459 10/24/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Th. The am Shar man Unally, Ad, まるに E117 21093 32. Signature State ²5 2005 Registrar

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			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment of F	lealth and <i>Death</i>		Reg. No.	05	34399
	Physici	an	Decedent's Name (First, Middle, La	st)			Mitch		2. Date of Dea	Day	Year	3. Time of Death
	/Medic		KegeHa 4a. Facility Name (If not institution, given	e street and number)			4b. City, Town, o		October		2005 ounty of Death	12.36 4
	Exami	iei	The Johns Hopki		tal		Baltime		Y			
	Funeral		5. Social Security Number 6.5		e (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h V, Year) 1 0	9. Birth	olace (State or Foreign ntry) nnsylvania
	Director		Usual Residence of Decedent	- X- O	/	Yrs.			may 19,	1910	re	nnsylvania
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limits
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	with th	Dire	10e. Street and Number 2930 Alconbury C	ourt			10f. Zip Code	1009			of What Coul	ntry?
20	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: if tiem 27 is marked other then "natural", or items 23e or 28a-f show injury or other treumatic event. I'm M. Alcul Ext. Jing I Mail by Intilitied at fingure of the Intilitied at 8.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		(Specify Yes or No- into Rican, etc.)	14.	Race · Americ Black, White,	
2-003e	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation	orking	16b. Kind	of Business/In	dustry
7		Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	i+)			during most of w d)	orking		1	_
7	filed within Hygiene. other then other and.		12 years 17. Father's Name (First, Middle, Lasi	}		пош	emaker	18 Mother's N	ame (First, Middle,		wn hom	e
yland	ld be fental h	To Be	James Lettiere	,					Ferraro		marrie)	
_	shou and M s mar	-	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address (Street	and Number or F	Rural Route Numbe	r, City or To	own, State, Zip	Code)
, Ma	and 2 ealth a n 27 is		Dennis Mitchell/	son					Bel Air,			
ore	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then 'any injury or other treumatic event. If a Mande.		20a. Method of Disposition 1 A Burial 2 Cremation 3	Removal from State	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place	(e)	Date	20c. Locat	ion - City or To	own, State
altimol	it. Pa irtmen irtant: njury njury		' 4 □ Donation 5 □ Other (Special Service) ce		Be1	l Air l	Memorial	Gdns. 1	0/25/05	Be1	Air, M	d
מ	Depa Impo any it		1948. CO				Schimunek	Funera	l Home of Road, Bel	Bel	Air, I	nc. 1014
	Physician pe executed attending physician and attending physician and per research to the period of	i Examiner	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aspira Due to (or as b. Due to (or as C. Due to (or as	tion a consequentia a consequence	Pnew uence of): uence of):		9, 000. 00				Approximate Interval Between Onset and Death I day
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O. BOX 6	the d	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	•		23d	. Date of delive	ery Day Year
cords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I.		es 2□N		he cause of death?
T U	The law ate has t page 2 s	Completed										psy findings available mpletion of cause of 2 No
VII	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00	eath (Check only o			
ō	this a	To To	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date of Inju	ry	ER/Outpatien 28b. Time of	I 3 DOA	4 🗆 Nursing	Home 5 ☐ Resid			y)
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UNIS	tel or Attending F rs after death. el Director: After ed in by the funer.	Certification:	3 Suicide 6 Could not be determined		ury - At ho c. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and N m, State)	lumber or Rura	al Route Number,
	o the Hospitel or Al within 24 hours after of To the Funerel Direct completely filled in by	edicai	(Check only 2 Medicel Exe	nysician: To the best miner: On the basis of and manner sta	f examinat	wiedge, death tion and/or in	vestigation, in my o	pinion, death occ	curred at the time, o	date and pla	ace, and due to	the cause(s)
	o v	Σ	29b. Signature and title of certifier			_	29c. Licens				igned (Month,	
	10		Deida C. Cu	eus, Med	cal	Docto	KES	- 000	10	ctobe	r 21, 2	.005
C)		Deidra C. Creus To	a Johns Hook	سليا أمرحك	اللثمع	(no sloval.	Wolfest	reet Baltil	ntore M	Varyland	21287
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State of Maryland / Department of Health and Mental Hygiene 0 5 Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) ^D19, 2005 **Physician** October 2220 Julia Mullan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cecil Sunbridge Rehab. & Nursing Home E1kton If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2₽F 83 Yrs. 141-34-6907 April 12, 1922 Italy Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 1∩a State 10c. City, Town or Location nam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant, the Nedford Examinations to notified ut 1 ☐Yes 21 No Havre de Grace Md. Harford Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21078 U.S.A. 2085 Titan Terrace Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Itams 23 Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) coat factory seamstress 2 years 17. Father's Name (First, Middle, Last)
Artillo Telese 18. Mother's Name (First, Middle, Maiden Surname) Be unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2085 Titan Terrace, Havre de Grace, Md. 21078 Carol Tredo/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ò permit. Page Department of Important: If any injury or once. 10/21/2005 Baltimore, Md. Bayview Crematory ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. MacPhail Road, Bel Air, Md. 21014 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death lioblastoma Immediate Cause (Final disease or condition resulting in death) Unknown Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Hypertension Diabetes Mellilin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Viursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending 1 TYes death. investigation 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 THomicide within 24 hours a To tha Funaral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 118 North of Stille 3B, Elklon MD 24921 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiege Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** PN CRACI ARIS MORMAN /Medical TOUR 3002 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE FRANKLIO QUARE HOSPITA If Under 24 Hrs.
Hours Min.

NAYAL 193 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) 10 M 2 F Months Director 2046 66 816 JARYLAN (Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f shov other traumatic avent, it a Medical Examinar must be notified at 1 ☐ Yes 2 No Directo CHARAGIO BALTimoRE IRRY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 21236 Funerai 12. Was Decedent Ever in U.S. Armed Forces? ↑22 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: þ 3 Widowed 4 Divorced Specify. Year or Dates: W. Will WHITS Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withit Depertment of Health and Mental Hygiene (important: if item 27 is marked other than any injury or other trailmatic. EASTER! Elementary/Secondary (0-12) College (1-4or 5+) BRICKLAYER 5YRS 12 SV 11072 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTER, DOLPHUS HAMMORD HIL Viola II ΛZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 22HZZ3 4300 1 JICKI ERRY HALL 20b. Place of Disposition (Name of comptent, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 26770 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specky) TIHTES 10-1 LIMENT AUC 21. 3 g Mary f Fun ra Service Licensee 22. Name and Address of Facility
EVALL CHARLOF OF ROAD
8800 HALFORD ROAD 21234 ROPO PARKVILLE 1ARTLAND 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGEST Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence or. Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2X No 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 🗌 Yes 2**5** No ER/Outpatient 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 28a. Date of Injury (Month, Day Year 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending TENatural 5 Pending within 24 hours after death. To the Funeral Director: A М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of ath (Item 23a) (Type, Print) 6 31. Date filed (Month, 32. Registrar's Signature Coaste State Registrar

Amend item#8, perfn, 6846.10-31-65 Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefe 15 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1640 PM 2005 Ρ. October Margaritis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore fospita Saint Agnes 8. Date of Birth (Month 1939, Year) Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F Yrs. 216-50-1376 55 June 🗲 1950 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Catonsville Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 209 Stonewall Road 21228 U.S.A. 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itams 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify þ White 3 ☐ Widowed 4 ☐ Divorced naturei', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. other then? College (1-4or 5+) Elementary/Secondary (0-12) HCFA Health Care Social Security other permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 Is marked other events injury or other treumatic avents. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lavinia Sims James Margaritis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 209 Stonewall Road Catonsville, MD 21228 John Margaritis (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Greek Orthodox Cem. 10-21-2005 4 □Donation 5 □Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Ligenses 1630 Edmondson Ave. Catonsville, Maryland 21228 Approximate Interval Between Qnset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Rena **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Failure detached for use as the burial-transit teart that initiated events resulting in death) Last and Due to (or is a consequence of): attending physicien Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Month Vear Day 4 Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate Margaritis To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 Dinpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27 Manner of Death
Divatural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 completed came of death (Item 23a) (Type, Print) 30. Name and address 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

			For State of Maryland / Department of Health and the State of Maryland / Department of Health And Maryland / Department of Health And Maryland / Department of Health / Department of Health / Department of Health / Department of Health / Department / Departme		Reg. No		34403
	Physici	an	1. Decedent's Name (First, Middle, Last) Stanley Melvin Marcinski	2. Date of De		l ^y , 2005	3. Time of Death 10:25 Am
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			. County of Dea	th
	3		Gilchrist Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi	rth	Baltimo	
_	Funeral Director		220-14-3817 17 78 Yrs. Months Days Hours Min.	8. Date of Bi	y Year	1927 N	thplace (State or Foreign ountry) Maryland
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f et	ector	MD n/a Baltimore City		10- 0		1 X Yes 2 No
	h with ti	ai Dir	4100 North Charles Street # 515 10f. Zip Code 21218		log. Cl	itizen of What Co JSA	ountry ?
9800	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "naturel", or Itama 23a or 28a-f ehow aumatic event, the Martical Exerts or must be southed.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, 3 No If Yes, 3 No Year or Dates: 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerly Yes, Give Year or Dates:	pecify Yes or N to Rican, etc.)			te, etc. Vhite
1215-(within 72 h ene. than "natu he Mydica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	rking		Cind of Business	Agency
d 2	e filed al Hygid other vent, I	Be Cc	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle	e, Maidei	n Sumame)	
7 <u>7</u>	2 should b and Menta Is marked aumatic e	To E		ia A. Za			Zin Code)
Na.			Frances Marcinski/wife 4100 N. Charles Stree		Bal	timore,	MD. 21218
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other t 2008.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Holy Rosary Cemetery 10/2		Ва		, Maryland
Balt	permit. Departi Importi eny inj		21. Sign thre of Juneral S. vio Licensee S. Coster 22. Name and Address of Facility Records 1050 York Road,				Home, Inc. 21204
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory a	arrest,		Approximate interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Usun Cur Cer Due to (or as a consequence of):				yens
8).	Examiner	1	Sequentially list conditions, Due to or as a consequence of):				
_	cuted nd name it	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
68760,	eath certificate be executed attending physician and for use as the burial-transit	at Ex	resulting in death) Last Due to (or as a consequence of):				
	ntificate ing phy: e as the	Medical	IF FEMALE:	-	- 1		
0. B₀	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 5 Other (specify)			23d. Date of de Month	livery Day Year
10(21/0 rds, P.	w requires that the de been signed by the s should be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco Yes 2	.,	o the cause of death?
الله Reco	The law re ate has bee page 2 sho	Completed		24a. Was auto perf 1 Yes	s an opsy ormed?	death?	utopsy findings available completion of cause of
ار Vital	ilcian: certific rector.	Be	25. Was case referred to medical examiner? Hospital:			- 400	· In ac no.
Mysc n	ng Phys ter this neral di	n: To	27. Manner of Death 28a. Date of Day York 1	28d. Describe			ocity) NOSPICE
STANILE MARCINSEL 10/21 Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Hornicide determined (Nothin, Day Year) Injury M 1 ☐ Yes 2 ☐ No 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street a	nd Number or R e)	ural Route Number.
SES.	Hospital or 1 24 hours efter Funeral Dire letely filled in b	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation.	e, and due to the urred at the time	cause(s	s) and manner a od place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number			ate signed (Mon	
	ntl		20 Name and address of passes who completed gauss of death (Item 32a) (Type Print)		OCT	over 4	1000
3	of an		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMAN J. Charles MD 6601 N. Charles ST TOMS	on my	2	1204	
	Sta Registi		31. Date filed (Month, Day, Year) 11. Date filed (Month, Day, Year) 12. Segistrar's Signature			1	

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	rtificate of l		Reg	2005	34404
l	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Marjorie	С.	Me	haffey		2. Date of Death Month October	Day 2005	3. Time of Death 10:00 a M
	Examin		4a. Facility Name (If not institution, give s 8820 Walther B	street and number) 1 v d . #160	7	4b. City, Town, or Parkvil	Location of Death		4c. County of Deat Baltimor	
Ī	Funeral Director		5. Social Security Number 6. Security Number 157-09-3469	7. Age	(In yrs. last birthday) 86 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug. 26	g Rin	hplace (State or Foreign Suntry) Pth Carolin
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Md. Baltimor	·e	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	h with the 23e or 28s	Funeral Director	10e. Street and Number 8820 Walther Blvd	1. #1607		10f. Zip Code 21234		10g	. Citizen of What Co	•
030	n 72 hours after deeth with the Maryland "natural", or items 23e or 28e-f ehow adical Extrairet must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	lo l	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
1213-003	filed within 72 ho Hygiene. Wher then "netur ent, the Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	+) 16a. Dece (Give life.	dent's Usual Occupion of work done of work done of DO NOT use retired Employed	ation Ju <i>ring</i> most of worki I)		b. Kind of Business	/Industry
yland	be filed stal Hygi of other	Be	17. Father's Name (First, Middle, Last)	200				(First, Middle, Ma	iden Sumame)	
Maryla	s 1 and 2 should I Health and Men Item 27 is marke other traumatic	P	Ophir Carmel Na 19a. Informant's Name/Relationship (Ty Mrs. Kathleen McDa					al Route Number, C	ity or Town, State, 2 Md. 21237	
စ	# O		20a. Method of Disposition 1 □ Burial 2 ① Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of Dispersion of Di	- Western	(9)	-	c. Location - City or	Town, State
Baitimo	permit. Page Depertment Important: if any Injury or once.		21. Signature of Funeral Service Licens	9	2	2. Name and Address RUCK TOW 1050 Yor	ss of Facility Son Funer K Rd. Tow	al Home,	Inc 21204	
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each lin	the death. Do not en	iter the mode of dyin	g, such as cardiac o	or respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner	PL	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0	a consequence of):					
oʻ	icate be executed physicien end s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):					*************************************
58/50,		edical		1.						
C. BOX	the death certific. y the ettending pl iched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
cords, P.	law requires that the de as been signed by the 2 should be detached	δ	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the u	underlying cause give	en in Part I.			the cause of death?
Ů,	The lay	Completed						24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Z	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:	a Clepio:	ot all DOA Oth		(Check only one)	ce 6 □Other (Spe	
on or	ing Phy I. After this funeral d	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpatie ry 28b. Time o / Year) Injury	of 28c. Injun Work	y at	28d. Describe how		city)
DIVISION	al or Attending setter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, st c. (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical			of my knowledge daar examination and/or in ited.					
	To the To the Complet	X	29b. Signature and title of certifier	nico		29c. Licens	e number	29d	Date signed (Mont	h, Day, Year)
			30. Name and address of person who co		eath (Item 23a) (Type		olevero	Parku	ille mo	21234
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 5 2005	32. Registra	ar's Signature	رز				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieze Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day M **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner timore 59 More Kena ti Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 7. Age (In-yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 586 Months Days 212-1 M 2 □ F 16-Yrs. Director Usuat Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, the Medical Examplest must be netited at 1 XYes 2 ☐ No Funeral Director Maryland more 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Apt 31 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Item any injury or other traumatic event, the Mental or 1000. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give / Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Completed by 3 ☐ Widowed 4 ☒ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Moţher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mood ٥ 19a. Informant's ame/Relationship (Type, Print) grandson) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) allow 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10 00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensep 22. Name and Address of Facility Home P.A. Joseph 2222 N on L. Rus neral Ave nat eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1/Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death VNG Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate sauss. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the be detached 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 3 ☐ Probabiy 4 🐧 Únknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 (No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical examiner? Other: Hospital: 4 Nursing Home 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Path 28d. Describe how injury occurred 28b. Time of 1 Naturat 2 Accident 5 Pending investigation 1 Tyes 2 🗆 No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

9 State

KHETERPAL 31. Date filed (Month, Day, Year) OCT 2 5 2005

29b. Signature and title of certifier

BACK 201 32. Registrar's Signature

O and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D0060560

RIVER NECK BY # 109

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryland /	Department of Health and I Certificate of Death		2005	34406
	Physici /Medic		1. Decedent's Name (Arst, Middle, L	1 11		2. Date of Death Month	Day Year /9 200;	3. Time of Death 5:05 P M
	Examir Funeral Director		4a. Facility Name (If not institution, g 1015 WAK 5. Social Security Number 2.18 · S8 · 4512	ive street and number) D Sex 1 M 2 F 7 Age (In me. last b.	4b. City, Town, or Location of Death ATTIMOR inthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	E	4c. County of Deal	thglace (State or Foreign
	pur 🛊	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	or Location ATIMORE	- VILY 5/	1102	10d. Inside City Limits 10 Yes 2 No
	th with th	ai Director	10e. Street and Number 1415 WA	RD CT.	10f. Zip Code 21205	100	g. Citizen of What Co	. /
960	ours after death with the Maryla ral', or Items 23s or 28s-1 shor Examirer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Curan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Item 27 Is marked other than "natural", or Ite other traumatic event, Ir.a Mudical Examira	Completed	15. Decedent's (Specify only highest g	Education 16a rade completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) OPERATER	king	Sb. Kind of Business	Industry MUNI CATTON
yland	should be filed withir and Mental Hygiene. I marked other than umatic svent, Ire M.	To Be	17. Father's Name (First, Middle, La: Racht	HARTGROVE	18. Mother's Nan	ne (First, Middle, Ma ANNIE	B. PE	M
Baltimore, Mar	permit. Pages 1 and 2 sho Department of Health and Important: If item 27 la my any injury or other trauma once.		19a. Informant's Name/Relationship LVIV 20a. Metrod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	S (SON) Qualification (State) A (SON) 20b. Place of comments (Son) A (SON)		Date 20 S.05 B	CTIMORE DE LOCATION - City or DATIMORE - CREEN	MD2/224
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_	e Hospital 124 hours a s Funeral I	Medical Co	29a. Certifier Certifying F (Check only one) 2 Medical Ex-	Physician: To the best of my knowledg Iminer: On the basis of examination and and manner stated.	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me		o completed cause of death (Item 23a)	29c. License number) 2 4 7 4 0 (Type, Print)		Date signed (Mont) Control C	n. Day, Year) an 2005
	Sta Registr	- 1	THORS A 31. Date filed (Month, Day, Year) OCT 2 5 20	32 Registrar's Signature	TOHNS HOCKINS F	WHICH L	127 2 1 1 1 10	

State of Maryland / Department of Health and Mental Hygiene 105 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** LORETTA JANE MUTH OCTOBER 19,2005 1:10 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 16, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Pennsylvania 217-40-8660 1941 64 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow event, the Mudical Executaer must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Rodgers Forge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21212 7202 Lanark Road U.S.A. or Iteme 23a death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify 3 ♥ Widowed 4 Divorced White 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home years Pages 1 and 2 should be filed and the part of Health and Mental Hygis sut: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Samue1 McClure Dripps .Jane Kassler other treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Samuel A. Muth (son) 101 Cherry Street Jersey City New Jersey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite eny injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-20-05 Green Mount Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 poce 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Tenanse Approximate Interval Between Onset and Death **Physician** ADULT RESPIRATORY DISTRESS SYNDROME 29 DAYS disease or condition resulting in death) /Medical Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated evenIs resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day ę Month Year 5 Other (specify) detached 9 Unknown sete has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No this certificete 1 ☐ Yes 1 Tyes director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 1 ☐ Yes 1 Inpatient Certification: To 2 No 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death the Director: 6 Could not be determined 3 Suicide within 24 hours after do Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) filled in by 4 Homicide 1🕉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D 26594 30. Namp and address of person who completed cause of death (Item 23a) (Type, Print) PEMMY CHHIM M.D 7601 OSLER DRIVE TOWSON MARYLAND 21204 \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Giuseppe Maruffi Sr. October 23 2005 4:00% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 N. Ellwood Avenue Baltimore n/a If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F 66 Director 215-74-2021 Yrs. 9/28/1939 Italy Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show MD n/a Director Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 N. Ellwood Avenue Items 23a Italy 21224 death by Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" ~... any injury or other traumatic exercises. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No White Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation

16a work done during most of working Completed 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Assistant Restaurant 2nd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Domenico Maruffi Maria Camia 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Maruffi 17 N. Ellwood Ave., Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/2005 Baltimore,MD Oaklawn '4 □Donation 5 🛮 Other (Specify) entomb. 22. Name and Address of Facility Joseph N. Zannino, JR. FH 21. Signature of Funeral Service Licensee 263 S. Conkling St. Baltimore, MD 21224 annice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician a detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ton 1 ☐ Yes 2 ☐ No 3 ☐ Probably nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 553100233 myleyed cause of death (Item 23a) (Type, Print) 80 31. Date filed (Month, Day, Year) State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MCNEILL РМ 2005 1:3010.16. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA ROCK GLEN NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 216.2A. 9732 86 04.20.1919 NC Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits worle ! r than "natural", or itame 23a or 28a-f ehov the Medical Examinar must be notified at 1 Yes 2 □ No MD NA BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 21216 USA 2315 N. LONGWOOD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 KZYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd 2 should be filed within 7 slih and Mental Hygiene.
27 le marked other than *r treumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 514 GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) IRA EFFIE FELLOWS BAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2::
Department of Health ar
important: If Itam 27 le
any injury or other treu ST., (DAUGHTER) 209 MT. HOLLY BALTO. MO ANNA WILSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 110.24.05 OWINGS MIUS, MD 21. Signature of Funeral Service License VAUGHN C. GREENE FUNERAL SERVICE lange 5151 BAYO. NATU PIKE, BAYO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 **Physician** /Medical Due to (or as a consequence of): Examiner ed my elitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Ó 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ certificate has been signirector, page 2 should be ernotremi 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Nemia 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No of Vital after death.

Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4週 Nursing Home 5 日 Residence 6 日 Other (Specify) 1 Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 🛣 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number vince 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MJ. Michael awrence 🗳 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 2 Registrar 5

IAL	D MAYN	OR	1- For Unpend Item Registrar		Marylar 11,27,2	d / Depa 8a-1 p Cei	artment of the control of the contro	lealth and Death	d Mental Hygi Cas	ene 005	34411
	Physici /Medic		Donald Maynor	st)					2. Date of Death Month OCT •	Day Year	3. Time of Death 4:18 P M
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	Funeral Director		Social Security Number unk Social Security Number unk	Sex	7. Age (<i>In yr</i> s. 49	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	8. Date of Birth (Month, Day, Oct 14,	Year) 9. Birt 1955	hplace (State or Foreign buntry) unk
	tiffed at	ctor	10a. State 10b. County MD	-	10c. Ci	ty, Town or Lo					10d. Inside City Limits 1
40.00	s I and 2 should be lied within 72 hous after beath with the maryland that had Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 2200 Linden Avenu 11. Marital Status unk 1 □ Never Married 2 □ Married	12. Was Dece Armed For 1 Yes		J.Sunk 13.	10f. Zip Code 212 Was Decedent of H f Yes, specify Cuba		(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Ame Black, Whit	rican Indian,
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IVISION OF VI	within 24 hours effer death. To the Funerel Director: After this certificete hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To B	examiner? 1 Y Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined	28a. Date o (Month 10-5-0) 28e. Place o	f Injury η, <i>Day Year)</i> 05	28b. Time of Found 4:15	at 28c. Injury	er: 4 🗆 Nursing	Peath (Check only one) Home 5 ☐ Residen 28d. Describe how 28f. Location (Street	ce 64Other (Spec	AT SCENE
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41.07	within To the comple	Me	29b. Signature and title of certifier	m.>	er stateu.		29c. License	number C.M.E	290	Date signed (Month	, <i>Day</i> , Year) 005
			30. Name and address of person who	mio	11	1 PENN	STREET,	BALTIMO	RE, MARYLAN	D 21201	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2, 5, 701	15 A	gistrar's Signa	ature Cook	de				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mantal Husia

			1 - For State Registrar	Cen	rtificate of Death		2005	34412
	Physici	an	Decedent's Name (First, Middle, Last	:()		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Corey L. Mason		T	Septembe	r 19, 2005	
	Examir	ier	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	th	4c. County of Death	
·	- Francis		154 North Gay St 5. Social Security Numberunk 6. S	reet_ ex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs	8. Date of Birth	O Bids	alana (Chan a Sani)
4	, Funeral Director		Usual Residence of Decedent	√ M 2 □ F 49 Yrs.	Months Days Hours Min			place (State or Foreign ntry) unk
	land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
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	ems err	Funeral	11. Marital Status unk		Was Decedent of Hispanic Origin? (3 If Yes, specify Cuban, Mexican, Puel	Specify Yes or No-	USA 14. Race - Ameri	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow Ilseal Exeminer must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 □ No UNK	1 ☐ Yes 2 ☐ No Specify:	ito nican, etc.)	Black, White,	etc. Lack
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Maryland	s 1 and 2 should f Health and Mer tem 27 is marks other traumatic		19a. Informant's Name/Relationship (ng Address (Street and Number or A			Code)
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Baltimore,	0 0 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State cemetery, crer.	matory or other place)	Date 20	c. Location - City or To	own, State
Ball	permit. Pag Department Important: any Injury o		21. Signature of Forteral Service Licen Ronald S.	Wade Director St	2. Name and Address of Facility Late Anatomy Boar altimore, MD 212	d 655 W. B	altimore S	treet
			23a. Part . Enter the disease, or comp shock or heart failure. List only	lications that caused the death. Do not ent	ter the mode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		COHOL INTOXICATI	OM		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	THOME THE GOING	014		
	Examiner		Sequentially list conditions.	b				
	be sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence of):				
3	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	a E		Due to (or as a consequence or).				
68760,	phys phys s the	edicai		d				
	certific nding p	5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			224 0-1-44-5	
Rox	death cer attendir d for use	Physician/I	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
r Ö	at the de by the	hys	9 Unknown	9□ Unknown				
	es that igned to be det	by P	Part II. Other significant conditions of	ontributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
ĕ	w require been sig should b					1 ☐ Yes	2 ☐ No 3 ☐ Prob	ably 4 Dunknown
Vital Records,	awre as bee 2 sho	Completed				24a. Was an	24b. Were auto	psy findings available
ř	The tete ha	E				autopsy	d? death?	psy findings available mptetion of cause of
<u>ख</u>		a)	25. Was case referred to medical		26. Place of De	1 X Yes 2 ath Check only one)	No 11X Yes	2 L No
>	d is	To B	examiner? 1 ½ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			e 6 DOther (Specifi	At Scene
0	ng Ph fter th neral	1	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 28b. Time of (Month, Day Year)	f 28c, Injury at	28d. Describe how	injury occurred	ALC DECITE
Division	Attending F r death. ector: After by the funera	atic	2 ☐ Accident investigation	found 9-19-05 Tound at	t M 1 ☐ Yes 2 XXX No	unknow	n	
≌	4 2 0 A	Certification:	3 ☐ Suicide 6 🕅 🕻 Wild not be determined	28e. Place of Injury - At home, 11 m, 's rebuilding, etc. (Specify)	e actory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	ral D			street		154 N. Ga	y St., Bal	
	To the Hospital or within 24 hours efter to the Funeral Director completely filled in	dical	(Check only 252 Medical Exam	ysician: To the best of my knowledge, death liner: On the basis of examination and/or inv	h occurred at the time, date and place vestigation, in my opinion, death occi	and due to the caus	e(s) and manner as st	lated.
	thin 2 the the mplet	Med	29b. Signature and title of certifier	and manner stated.				
	7 × 5		A	m.D	29c. License number		Date signed (Month,	,
		1	my m.		O.C.M.E.	Sep	otember 20	, 2005
			. (%)	completed cause of death (Item 23a) (Type, 111 Por	nn Street, Baltin	ore Marti	land 21201	
	e	00	UNG LI, N 31. Date filed (Month, Day, Year)	32 Registrar's Signature	ini Derect, Darelli	ore, nary	Laur ZIZUL	
	Sta		OOT 9 5 20	E-1986				

Catherine Neumayer 93% 10/20/05 Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		•	•	k Indelible Ink. Ensure	-	-	
		1 - State Registrar	-	Department of Health and Certificate of Death		gie2e0 0 5 Reg. No.	34413
Physic /Medi		1. Decedent's Name (First, Middle, Last) ATHERINE	C. NEUM	AYER	2. Date of Dea Month	Day Year	3. Time of Death 9 - 30 A-M
Examir Funeral	ner	4a. Facility Name (If not institution, give stood of the Carlot of the C	reet and number) E CENTER 7. Age (In yrs. last bir		rs. 8. Date of Birth		in ORE hplace (State or Foreign untry) ARYIAND
Director works		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow			7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	10d. Inside City Limits
the Mary 28e-f sh	rector	MD BALTIMO	DRE PAR	KU, I) E		10g. Citizen of What Co	1 Tyes 2 No
72 hours after death with the Maryland naturel; or Items 23e or 28e-f show deal Examination indiffer at	Funeral Director	9800 WALTHUR 11. Marital Status 1 Never Married 2 Married	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ Ho	21234 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
72 hours aft	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify: Decedent's Usual Occupation		Specify: Wh	177E Industry
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other then 'natural any injury or other treumatic event, the Medical angle.	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of work done during most of w life. DO NOT use retired) SECRETARY	vorking	OFFICE	Marie
should be filed within nd Mental Hygiene. i marked other then "umatic event, the Men	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle,	Maiden Surname)	
should and Me s mark umatic	J.	193 Informant's Name/Relationship (Typ	nmINGS e, Print) 19b	o. Mailing Address (Street and Number or		er, City or Town, State, J	Zip Code)
and 2 lealth a m 27 ls		PAUL NEUMAYER		14 CHARLES SPA	Date WAY	20c. Location - City or	
Pages 1 nent of He ant: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cemete	ry, crematory or other place) OF FAITH CEMETERS 29	105FR	ROSEDA	i E mD
permit. P Departme Importen any Injury		21. Signeture of Far eral Service License	The state of the s	22. Name and Address of Fecility	EVANS FO	MERAL CA	APEC
		1/6/2015	G.	8800 HARFOR	- /	PARKUITE.	mo 27234
Physician /Medical		23a. Part : Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Due to (or as a consequence	not enter the mode of dying, such as card	ac or respiratory at	1651,	Approximate Interval Between Onset and Death
Examiner	Н.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
ate be executed sysicien and he burial-transit	Ical Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):			
The Columb, F.C. BOX 00100, The law requires that the death certificate be evalue has been signed by the attending physicien page 2 should be detached for use as the burial	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	ivery Day Year
tuires that a signed build be deta	by P	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.		obacco use contribute t Yes 2□No 3□P	o the cause of death?
The law requires the law seem signed has been signed page 2 should be	Completed				24a. Was autop perfo 1 Yes	an 24b. Were a prior to death?	utopsy findings available completion of cause of
VII.al Icien: T certificat ector, pa	Be	25. Was case referred to medical examiner?	ospital:		Death (Check only o		74.1
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	1 Yes 2 No 27. May or of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	tipartient 3 □ DOA 4 Nursing Time of Injury M 28c. Injury at Work? M 1 □ Yes 2 □ No		dence 6 □Other (Spe how injury occurred	city)
LIVISION el or Attending s after death. il Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (S City or Tov	Street and Number or R wn, State)	ural Route Number,
e Hospit 24 hour e Funere letely fille	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledg er: On the basis of examination a and manner stated.	e, death occurred at the time, date and pland/or investigation, in my opinion, death or	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	s stated. a to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	2 ~~	29c. License number		29d. Date signed (Mon.	•
		30. Name and adds of person who co	moleted cause of death (Item 23a)	(Type Print)			eth Zess
0		30. Name and add of person who co	F800 W	(Type, Print) Bl.) Park	lle m	21231	1
S Regis	tate trar	31. Date filed (Month, Day, Year) OCT 2 5 20	32 Registrar's Signature	Sparke			

			For State Registrar	State of Maryland / Depa	artment of F rtificate of		ygiene Reg. No. 0 0 5	34414
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Law rence W; //,	am helson		2. Date of I Month	Death Day Yea	3. Time of Death
	Examir			TimExtended care	Balti	r Location of Death	4c. County of De	
	Funeral Director		5. Social Security Number 6. Security Number 128 · D1 · 4485 Usual Residence of Decedent	7. Age (In yrs. Jast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 8. Date of 8 (Month,	Dav. Year) (inthplace (State or Foreign Country)
	ith the Maryland or 28a-f show	ctor	10a. State 10b. County	10c. City, Town or Lo	rimore	•		10d. Inside City Limits 1 ☑ Yes 2 □ No
	ath with the 23e or 28	ral Director	803 E. FORT			21230	10g. Citizen of What C	
920	urs after de:	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No	Was Decedent of H If Yes, specify Quba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Specify Yes or I an, Mexican, Puerto Rican, etc.) Specify:		nerican Indian, lite, etc. UHTE
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Evant act must be incitited at	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+) (Give	DO NOT use retired	during most of working	16b. Kind of Busines	s/Industry
	ould be filed v Mental Hygie arked other t atic event, ID	To Be Co	17. Father's Name (First, Middle, Last) LAWRENCE	AUSTIN	ROAD	18. Mother's Name (First, Midd		
, Maryland	1 and 2 should be Health and Mental em 27 is marked (ther traumatic ev		19a. Informant's Name/Relationship (Ty MILORED NELSO	(WIFE) 803	E. tox	and Number or Rural Lute Num		Zip Code) 0 21230
Baltimore	Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 Pr 4 Donation 5 Other (Specify)	20b. Place of Dispo cometery, crea BREEN MA	matani or other plai		BATIMOR	
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Ligens	ee 22 4 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	905 YO	RK ROAD BAC	TIMORE, MO	2/2/2 Approximate
8760, <	Provided Medical Examiner Provided Prov	al Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	sectal	Carcinoma		Inferval Between Onset and Death
O. Box 6	death certificate e attending phy id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		⊒Ectopic pregnancy ∃ Other (<i>specify</i>) _	/	23d. Date of d Month	elivery Day Year
rds, P	w requires that been signed t should be dete	by	Part II. Other significant conditions col	ntributing to death but not resulting in the u	nderlying cause giv		d tobacco use contribute ☐ Yes 2 1 No 3 ☐ F	to the cause of death?
I Records,	2 2 2	Completed				24a. Wt aui pei 1 □ Yes	topsy prior to formed death?	autopsy findings available completion of cause of s
of Vital	ding Physician: The In. After this certificate hat funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year)		4 Nursing Home 5 He		ecify)
Division	l or Attending I after death. Director: After I in by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) Injury 28e. Place of Injury - At home, farm, st. building, etc. (Specify)	M 1	Yes 2 □ No 28f. Location	(Street and Number or F own, State)	Rural Route Number,
Q	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	h occurred at the tir	me, date and place, and due to the print of the print of the print of the time.	e cause(s) and manner a	us stated. ue to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	alimo.	29c. Licens 3 4 3	359(0H10)	29d. Date signed (Mor	nth, Day, Year)
	4		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, 3900 Lock Raven B	Print)	/	ryland 2/2	18
	° Sta Regist		31. Date filed (Month, Day, Year) OCT 2 5 2001	2. Registrar's Signature	Les .	4		

Division of Vital Records, P.O. Box 68760, A

Physicia	_	Decedent's Name (First, Middle, Last) HERMAN			NEUBERGE	R	2. Date of Dea Month OCTOBEI	Day	2005	3. Time of Death 6:00 P M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Dea		7	ounty of Death	0.00 1
Examin	G!	401 YESHIVA LANE			BALTIMO	RE		В	ALTIMOR	RE
Funeral		5. Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h (Year)	9. Birth	place (State or Foreign
Director		210-30-6/03	W 2UF 8	37 Yrs.	,		06/26/1	918		GERMANY
Manual Ma	-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
f sh	tor	MD BALTIMO	RE	BALTIMO	RE					1 □ Yes 2√□ No
iurs alter death with the Marylan al', or iteme 23a or 28e-f show Examinar must be notified al	Director	10e. Street and Number			10f. Zip Code			10g, Citize	n of What Cou	ntry?
th wit		401 YESHIVA LANE	APT. #1-A		21208			U	.S.A.	
teme teme	Funeral		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14	. Race - Ameri Black, White	
rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		S	pecify: WH	ITE
etura etura	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/Ir	ndustry
be filed within 72 hours after death with the Maryland ist Hygiene. Ist Hygiene. of done 128 or 28e-f show other the Medical Examinar must be notified all event, the Medical Examinar must be notified at	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of wo d)	orking			
ygien ygien t. the	Completed		5+		DEAN	r			CATION	
be fill half H ed off	Be	17. Father's Name (First, Middle, Last) MAX		NEUBER	GFR	BERTHA	ame (First, Middle,	Maiden Si	umame)	HILLER
should nd Mer marke	ဥ	19a. Informant's Name/Relationship (Ty	roe Print)				Rural Route Numbe	r City or l	Town State Zi	
and 2 sealth an n 27 is in treu			SON	1			- BALTIM			
f Hea f Hea item		20a. Method of Disposition	20h	Place of Dispo	sition (Name of		Date		ition - City or T	
Pages nent of int: if it		1 🛱 Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	SESOMON	TEFTORE HEBREW C	ONG 10/	23/05 22/2005	BALT	IMORE,	MD
permit. Pages 1 and 2 should be filed within 72 ho popariment of health and Mental Hygiene. Important: If Item 27 is marked other then "netur eny injury or other treumatic event, the Medical <u>once.</u>		21. Sign y a Funeral Service Lightns			2. Name and Addre		OL LEVINS			
20 E 9 9		William !	nuger			TERSTOWN	ROAD - I	PIKES		MD 21208
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or						rest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	0-pul	MON ARM	ARRE	ST			Myediet
Examiner		ſ	Due to (or as a cons	equence of):						
	er	if any leading to immediate	Due to (or as a cons	equence of):						
outed	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
be executed ician and burial-transi		resulting in death) Last	Due to (or as a cons	equence of):						
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etten for u	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fi 4 Pregnant at time o	etal death 3	Ectopic pregnanc Other (specify)	у		23	Month	Day Year
t the d by the ached	hysi	9 Unknown	9□ Unknown							
s tha	oy P	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use	contribute to	he cause of death?
equire en sig ould b	ted	144 PERTENS	DN				1 🗆 Y	es 💥	No 3 ☐ Pro	bably 4 Unknown
lawr as be	Completed						24a. Was autop	sy	prior to co	opsy findings available impletion of cause of
the cate h	Con						perfor 1 ☐ Yes	med? 2000	death? 1 ☐ Yes	2 No
ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		. 04	200	eath (Check only o			
Phys rthis ral dir	. To	1 Yes 2 No	1 ☐ Inpatient 2	☐ ER/Outpatier	IL 3LI DOA	4 Nursing	Home 5 Resid			fy)
ding th. Afte	tion	Natural 5 Pending Accident investigation	(Month, Day Year,) Injury	Wo	rk?]Yes 2∐No		, ,		
Atter	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and	Number or Aur	al Route Number,
rs afte	Certification;	TOTAL CONTROL OF	building, etc. (Spe				City or Ton	n, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only / 2 ☐ Medical Exami	sician: To the best of my kiner: On the basis of exam	nowledge, deat	h occurred at the tr	me, date and place	ce, and due to the courred at the time.	ause(s) a	nd manner as s	stated. o the cause(s)
thin 2 the the mplet	Medical	29b. Signature aftd title of certifie	and manner stated.		29c. Licens				signed (Month,	1
5 ± 5 8		250. Signature direction of continue	111			5039	'		/22/0	
12		30. Name and addless of person who co	ompleted cause of death (I	tem 23a) (Type						
1			BOUTS, MD	283	5 Smit	h Ave	BA/+	. 170	2/20	9
Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Sig	gnature	Carrie a		BAlt			
	ar	OCT 2 5 20	105 Breeves	S. A.	NEARL!					
Registr		N7 -					-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For Amend Ite Registrar 1. Decedent's Name (First, Mic			06	runcate	OI Death		Date of Death		3. Time of Death
	ROBERT CROM	WELL	OWENS,	III			0	Month CTOBER		Year 05 1:25 P M
	4a. Facility Name (If not institut	on, give str	reet and number,		4b. City, To	own, or Locatio			4c. County o	
A y							or 24 Hrs. I o	D. 1 1 D. 1		RD CO
	066-74-2063	1		ge (in yrs. iast birthda) 21 Yrs.			s Min.	(Month, Day, Y	1983	Birthplace (State or Foreign Country) NY
	Usual Residence of Decedent	h.		10c City Town or I	acation			,		10d. Inside City Limits
ō			IINDEL.	Toc. City, Town of L		N BURNT	E.			1 Tyes 2 No
rect	10e. Street and Number	ML AIC	ONDEL					10g	g. Citizen of Wi	hat Country?
a	140 CARROLL	ROAD				21060				USA
uner	11. Marital Status		Armed Forces	?	Was Decede If Yes, specif	nt of Hispanic (Cuban, Mexic	Origin? (Specify can, Puerto Ric	Yes or No- an, etc.)		- American Indian, , White, etc.
þ			If Yes, Give Year or Dates:	'MO	1 ☐ Yes 2	No Speci	fy:		Specify:	WHITE
eted	15. Deced	ent's Educa	ation completed)	16a. Dec	edent's Usual	Occupation	ost of working	16	b. Kind of Bus	
mple	Elementary/Secondary (0-12			5+) life.					TIN	THEDCTON
ပိ		e, Last)			2100		ther's Name (F	irst, Middle, Ma		IVERSITY
0	ROBERT C. OW	ENS,	Jr.			P	PATRICIA	L. GRO	OHOLSKI	
	19a. Informant's Name/Relatio	nship (Type	e, Print)	19b. Mai	ling Address (Street and Nun	nber or Rural R	oute Number, C	City or Town, S	itate, Zip Code)
		ENS,	Jr./ fat		and the second section is a second		_			
	1 🗆 Burial 2 💢 Crematio		moval from State	cemetery, cri	ematory or oth	er place)	1			5-9-7
	Mark le	. Yas	nure	Mo1357	1 SE	COND AV				-
2.54	shock, or heart failure. L	or complications on the complete on the comple	ations that cause cause on each	d the death. Do not eine.	nter the mode	of dying, such	as cardiac or re	espiratory arres	t,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a.			licated	By Ast	thma			
			Due to (or as	s a consequence of):						
ner	if any, leading to immediate cause. Enter Underlying	J ^{6.}	Due to (or as	a consequence of):				-		
каш	Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or a)	a consequence of):						
			220.00(0.20	, a sonosquonos sij.						
	15 55144 5									
an/N	23b. Was decedent pregnant	23	1 Live birth	2 Fetal death 3						of delivery
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4☐Pregnant a 9☐Unknown	it time of death 5	Other (spec	cify)				54,
y Ph	Part II. Dther significant cond	itions conti	ributing to death	but not resulting in the	underlying cau	ise given in Pai	rt I.	23e. Did toba	cco use contri	oute to the cause of death?
								1 ☐ Yes	2 No 3	B ☐ Probably 4 ☐ Unknown
plet				-4.				24a. Was an autopsy	pr	ere autopsy findings available for to completion of cause of
듓								1 Yes 2		h? Yes 2□No
101		cal				26. Pla	ace of Death (C	heck only one		
o Be C	25. Was case referred to medi examiner?		spital:	inst 2 FR/Outpatio	aM no.	Other:	Aluraina Hama	E Donidos	· · · ·	(6
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	To Be Completed by Funeral Director	ROBERT CROM 4a. Facility Name (If not institute HOWARD COUNTY 5. Social Security Number 066-74-2063 Usual Residence of Decedent 10a. State 10b. Coun MD AN 10e. Street and Number 140 CARROLL 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorce (Specify only high Elementary/Secondary (0-12 12 17. Father's Name (First, Middle ROBERT C. OW 19a. Informant's Name/Relation ROBERT C. OW 20a. Method of Disposition 1 Burial 2 Normation 4 Donation 5 Other 21. Signature of Funeral Service Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II, Other significant conditions	ROBERT CROMWELL 4a. Facility Name (If not institution, give str. HOWARD COUNTY GEN. 5. Social Security Number 066-74-2063 Usual Residence of Decedent 10a. State 10b. County MD ANNE AR 10e. Street and Number 140 CARROLL ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educe (Specify only highest grade) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) ROBERT C. OWENS, 19a. Informant's Name/Relationship (Type ROBERT C. OWENS, 20a. Method of Disposition 1 Burial 2 Normation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Buter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. 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List only one cause on each I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Leave 1 Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Leave 2 Sequentially list conditions, if any, leading to immediate cause (Final disease). In the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death the past 12 months? 1 Yes 2 No 9 Unknown Part II. 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Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mai ROBERT C. OWENS, Jr./ father 20a. Method of Disposition 1 Burial 2 (Cremation 3 Removal from State) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Anaphylaxis Compined (Squentially list conditions if any, leading to immediate Cause (Final desays or condition resulting in death) Last 10b. Was decedent pregnant in the past 12 months? 1 I Tyes 2 (No.) 23b. Was decedent pregnant in the past 12 months? 1 I Tyes 2 (No.) 21b. Due to (or as a consequence of): 22c. If yes, outcome of pregnancy (1 Live birth 2 Fetal death 3 Due to (or as a consequence of): 22c. If yes, outcome of pregnancy (1 Live birth 2 Fetal death 3 Due to (or as a consequence of): 23c. 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Facility Name (if not institution, give street and number) 4b. City, Town, or Location COLUMBIA 5. Social Security Number 066-74-2063 1 XM 2 F	ROBERT CROMWELL OWENS, III 4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL 5. Social Security Number O66-74-2063 10X 2 F 7. Age (in yrs. last birthday) O66-74-2063 10X 10 F 10C. City, Town or Location O66-74-2063 10X 2 F 7. Age (in yrs. last birthday) Mortis Days Hours Min. 8. OLD Hours Mortis Days Hours Min. 9. Hour	ROBERT CROMWELL OWENS, III OCTOBER	ROBERT CROMWELL OWENS, III

Elouise Oliver

			For Stata Registrar		State of M	aryland		rtment of H		Mental	Hygiene Reg. No	000	34417
			Decedent's Name (First, and a second se	Middle, La	ist)						of Death		3. Time of Death
	Physici: /Medic		ELOUISE R	. 01	IVER					Mon		A Sec	
	Examin		4a. Facility Name (If not inst	itution, gi	e street and number,			4b. City, Town, or	0		1	County of De	eath O
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	Funeral Director		5. Social Security Number 215. 24. 9751	1	Sex 7. A 1 □ M 2 🖾 F	90 (in yrs. 18 83	ast birthday) Yrs.	Months Days		in. (Mon	ih, Day, Year) 5.1921	9. 6	Birthplace (State or Foreign Country) MD
			Usual Residence of Decede	nt		03					3 · 144		
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	with the	Dire	10e. Street and Number		David			10f. Zip Code	^		10g. Cit	izen of What	,
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(0	r Iten	표	1 Mever Married 2□	Married	Armed Forces 1 ☐ Yes 2 📆	?		Yes, specify Cubai	n, Mexican, Pu	erto Rican, et	c.)	Black, W	hite, etc.
21215-0036	ral', o	þ	3 ☐ Widowed 4 ☐ Div	orced	If Yes, Give Year or Dates:			☐ Yes 2 © No	Specify:			Specify: 8	LACK
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an	should be ind Mental is marked o	To Be	ELSWORTH OL	VER					ALVIA	HINES			
Maryland	2 should have and have as main		19a. Informant's Name/Rei			\	19b. Mailir	g Address (Street a	n d Number or	Rural Route	Number, City o	or Town, State	
	1 and 2 s Health an em 27 Is i		ANGELA GAM	IER.	3004 (NIE			FAOMS MOC	D DR.		-		
altimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygene. If item 27 Is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, It a Medical Examinar must be notified at	1	20a. Method of Disposition 1 Burial 2 Crema	ation 3	☐Removal from State		ace of Dispo metery, crer	sition (Name of natory or other place	9)	Date	20c. L	ocation - City	or Town, State
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Baj	permit. Pages 1 ar Department of Hea Important: If item any injury or otha once.		21. Signature of Funeral Se	rvice Lice	en see	,	<u>v</u> A	Name and Addres	S of Facility	INERAL	SERVICE	01000	
			23a. Part 1. Enter the disea shock, or heart failure	se, or cor	nplications that cause	d the death		51 BAUD. No				21224	Approximate
	0 1		shock, or heart failure Immediate Cause (Final	. List only	100	_							Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)		Due to (or a		ience of):	-					2-TEARS
	Examiner				L								
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,09	cian a	Ü	1950king in doday cast		Due to (or a	a consequ	ierice or):						
8760,	physi s the t	dlcal			d								
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Box	death atter	Iclar	in the past 12 menths		1□Live birth 4□Pregnant a]Ectopic pregnancy] Other <i>(specify)</i>				Month	Day Year
P.0	that the ed by the detache	Physician/M	9 Unknown		9□ Unknown								
	Se DO	by P	Part II. Other significant co	nditions	contributing to death	but not resu	ilting in the u	nderlying cause give	n in Part I.	23e			to the cause of death?
ord	w requires been sign should be	ted								-	1 ☐ Yes 2	□ No 3 □	Probably 4 Unknown
Records,	aw 2 st	Completed								24a	. Was an autopsy	prior t	autopsy findings available to completion of cause of
E H	The gate	Con								10	performed? Yes 2 4	death	
Vital	iing Physicisn: Th n. After this certificate funeral director, pag	Be	25. Was case referred to mexaminer?	edical	Hospital:			Othe	26. Place of C				
of		-: To	1 ☐ Yes 2 ☑ No 27. Mann of Death		28a. Date of Inj (Month, D		ER/Outpatier 28b. Time of				Residence		pecify)
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	tai or s afte al Dir ed in	Certification:	4 Tromicide	,	building, e	nc. (Specify				0			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Me		hysician: To the bes								
	the hin 24 the f	Med	one)	ertifien	and manner s	tated.		29c. License					onth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland .		artment of F		d Mental Hy	giene		3	441	8
F	Physici	an	Decedent's Name (First, Middle,						2. Date of Do Month	eath Day	у `	Year	3. Time of	Death P M
	/Medic Examin		Michael Timothy 4a. Facility Name (If not institution,				4b. City, Town, o		OCTOBE!		County of	Death	10:40	I M
*			GOOD SAMARITAN 5. Social Security Number		e (In yrs. last	hirtholous)	BALTI MOF		re a Sata de Di					
	Funeral Director		215-42-7801 Usual Residence of Decedent	1 M 2 F 7. AQ	63	Yrs.	Months Days	Hours M		ay, Year)		Count	ace (State of ry) 1and	or Foreign
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	a or 2	Dire	10e. Street and Number	<i>#</i> F F A			10f. Zip Code	00/		10g. Cit	izen of Wh		ry?	
	death ms 23	Funeral	8710 Emge Road 11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	_ 1	234 Ispanic Origin?	(Specify Yes or Ne erto Rican, etc.)	0-	US 14. Race		ın Indian,	
0000	be filed within 72 hours atter death with the Maryland tal Hygiene. d other then "neturel", or items 23a or 28a-f show event, i're Medical Evaini act russi be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1	No		iYes, specify Cuba I□Yes 2万 No	n, Mexican, Pu Specify:	erto Rican, etc.)		Black, Specify:	White, e		
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7	vithin ne.	ompleted	Elementary/Secondary (0-12)	College (1-4or	5+)	lite. L	OO NOT use retired	1)						
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ומנומ	should be filed withir nd Mental Hygiene. marked other then imatic event, Tie M.	To B	Francis Xavier	O'Malley					an Shari]					
Mary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta										Code)	
ກົ	1 and 1 Health em 27	Charlene S. O'Malley/spouse 5615 Greenhill Avenue Baltiquere. Mb 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)										m State		
Ē	Pages nent of ant: ff it any or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ∏ Donation 5 ☐ Other (Specify)										vii, State		
Daltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Evant act must be notified at once.		21. Signature of Funeral Service Lin	wade, Alr	ector	St		omy Boa:	rd 655 W.	. Bal	.timo	re Si	treet	
3				omplications that caused	the death. D		. Itimore, er the mode of dyin		201 iac or respiratory a	rrest,	00E		Approximate Interval Bety	
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ממ	ath cer ttendin or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth			Ectopic pregnancy			2	23d. Date o			
5	v requires that the death certif been signed by the attending should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	1 5□	Other (specify)				Month)ay Ƴ	ear
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corus,	w requir been si should I		PULMONARY	HYPERTE					1 🗆	Yes 2[□No 3	Probal	bly 4 □U	nknown
ט		Completed	CHRONIC OBS	TRUCTIVE	PULI	MONA	IRY DIS	EASE	24a. Was autoj perio	an osy ormed?	pric	re autops or to comp oth?	sy findings a pletion of ca	ivailable iuse of
III	ding Physician: The lav h. After this certificate has funeral director, page 2	ø	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath Check only o	a No one)	1.	Yes 2	!□ No	
5	Physic this ce al direc	To B	examiner? 1 Yes 2 No	Hospital:		Outpatient		er: 4 🗆 Nursing	Home 5□ Resi		Other	(Specify)		
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2	al or Attendir after death. I Director: Af d in by the fur	Certification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Inj	ury - At home,	, farm, stre		2 110	28f. Location (Street and	d Number	or Rural I	Route Numb	pe <i>r</i> ,
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physicien: To the best eminer: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the timestigation, in my or	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and mann place, and	er as stat I due to ti	ed. he cause(s)	
	To t withi To tl	Σ	29b. Signature and title of certifier Ronugue 10	M.D			29c. License				signed (A			
							Res						12005	
			30. Name and address of person whe RENU GUPTA , GODD	SAMARITAN	HOSPITA	Type, F	GCI LOCH R	AVEN BO	ULEVARD,	BAL 21	71MOR 239	LE, M	HKYUHIV	U)
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 5 2	2005 Registra	ar's Signature	Spe	de la							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Perryman vaid 12:54 PM October 22 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MA University of MD Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/23/1962 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F 42 Director NEW YORK 072-60-6180 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r then "naturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits MD BALTIMORE OWINGS MILLS 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9105 THISTLEDOWN RD, APT.160 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. hours after 1 Yes Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) HOUSING SECURITY OFFICER 12TH LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental JAMES PERRYMAN HELEN CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9105 THISTLEDOWN RD, APT. 160, OWINGS MILLS 19a, Informant's Name/Relationship (Type, Print) . permit. Pages 1 and 2: Department of Health ar Important: If item 27 ie eny injury or other trau gncs. DELTRA PERRYMAN / WIFE Baltimore. 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 10/25/05 CATONSVILLE, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate shick or hear Imm. date Cause (Final diseas or condition resulting in death) **Physician** end renal stage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for se's consequence of Examine physicien and the burial-transit certificate be executed morbid 0665 Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2D No certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of : After t Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerei Director: completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospital Medical 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18578 MO Oct. 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Baltimore, MD 21201 ていいい JIMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 2 5 2005

			1 - For Stete Registrar	State of Ma			irtment of F tificate of		ınd Me		giene Reg. No.	005	34420	
			1. Decedent's Name (First, Middle, Last)					2	2. Date of De	ath		3. Time of Death	
	Physici /Medio		Vincent Joseph	Puzites					10	Month	R 22		5 0248 M	
	Examir		4a. Facility Name (If not institution, give St. Agnes Hospital)				4b. City, Town, o Boltomo	res N	1d.	21229	4c.	County of De	ath	
ŀ	Funeral Director		5. Social Security Number 6. Se 213-10-3265	X 7. Age M 2□F	(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Bir (Month, Da Oct. 1	th 19, <i>Year)</i> 5,191	(irthplace (State or Foreign Country) ryland	
	yland sow		10a. State 10b. County		10c. City, Town	n or Lo	ation						10d. Inside City Limits	
	Man,	to	Maryland Baltimo	re	(Cato	nsville						1 ☐ Yes 2X No	
	th the	Director	10e. Street and Number				10f. Zip Code	-			10g. Citiz	en of What C	Country?	
	23e (23e (23e (23e (23e (23e (23e (23e (al	223 Ridgeway Roa	d			2122	28			U.	S.A.		
21215-0036	be filed within 72 hours after death with the Maryland Hylygiene. Hylygiene. do other than "netural", or Itams 23e or 28e-f show avant, I're Modical Exatr and runt to indiffed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2☑ No	an, Mexican,	jin? (Speci , Puerto Ri	ty Yes or No can, etc.)		Black, Wh	nerican Indian, ite, etc. Thite	
2-0	ithin 72 ho ne. nan "netur Madical	ted	15. Decedent's Edu (Specify only highest grad	cation	16a.	Deced	ent's Usual Occup	ation	, , , ; -		16b. Kir	d of Busines		
21		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	kind of work done O NOT use retired	auring most d)	of working					
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ng	should be filed within nd Mental Hygiene. marked other than imatic avant, the M	Be	17. Father's Name (First, Middle, Last)							First, Middle,	Maiden .	Sumame)		
Z	should be ind Mental is marked o	To	Walter Puzites					Anna	01110	nown				
	2 8 8		19a. Informant's Name/Relationship (T) Vincent R. Puzite:				Address (Street						Zip Code) d 21228	
	ges 1 and 2 t of Health If Itam 27 or othar tr		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of	1	Dat	74.40			r Town, State	
JOI .	trent or tant: If jury or		1 🖾 Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Most H	y crem O LV	Redeemen	(e)	0 00	2005		•		
Baltimore,			21. Sign that of Furneral Service Licens		Cemete	22	Name and Addre	ss of Facility	0-26 -				Maryland	
B	Department of the sany in sany		Koemon	Talson	colu)) Wi	tzke Fun 30 Edmon	eral I	Home	of Cat	onsv	ille,	Inc.	
	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the	ne death. Do n							e, MD	Approximate	
	nysician :		Immediate Cause (Final disease or condition	ne cause on each mie		TC	SHOC	CK					Interval Between Onset and Death	
	/Medical		resulting in death)	a Due to (or as a									ONE HOUR	
	Examiner		Sequentially list conditions	Due to (or as a	SEF	251	5						Two DAYS	
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Cherry funderlying Cause (Disease or injury	Due to (or as a	consequence	of):		-					ONE MONTH	
	ecute and -trans	Examiner	that initiated events resulting in death) Last	·			EFT F	001	CE II	ULITE.	2		ONE MONIH	
8760,	cian cian curial			Due to (or as a	consequence o	ж):								
87	icate be executed physician and s the burial-transit	dlcal		d										
Вох 6	eath certific attending p I for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy						2	3d. Date of de	livor	
ğ	death atter	Physiclan/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti			Ectopic pregnancy Other (specify)				2.	Month	Day Year	
0	t the de by the tached	hys	9 Unknown	9□ Unknown										
Records, P	signed be de	by	Part II. Other significant conditions con	ntributing to death but RENAL	not resulting in			en in Part I.		_	obacco us ∕es 2∜⊈		o the cause of death? robably 4 Unknown	
O O	aw requas been 2 shoult	ompleted								24a. Was			utopsy findings available	
Ä	The I	mo			`					autop perfor 1 ☐ Yes	rmed?	prior to death? 1 ☐ Ye	completion of cause of	
Vital	i iclen: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place o	of Death (C	Check only o			22310	
of V	90 el	.0	1 ☐ Yes 2 No	lospital: 1 Anpatient	2 ER/Out	patient	3□ DOA Othe	er: 4 □ Nurs	sing Home	5 🗌 Resid	lence 6	□Other (Spe	ecity)	
	dis d	L The side of the								d. Describe h	ow injury	occurred		
Sio	ing Phy Mer this Ineral d			(Month, Day	<i>(ear)</i> In		Work? M 1 □ Yes 2 □ No							
	ling h. After fune		1 Natural 5 Pending investigation				_	Yes 2 □ No						
=	or Attending ifter death. Diractor: After in by the fune		1 Natural 5 ☐ Pending	(Month, Day 1) 28e. Place of Injury building, etc.	r - At home, far	m, stre	_	Yes 2 □ No		Location (S City or Tow	itreet and n, State)	Number or R	ural Route Number,	
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PUZI TES, VINCENT

MARY PARIS

Please Type or Prin	t in Black Indelible Ink.	Ensure All Copies Are Legible
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		For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artmer <i>tifica</i> :	nt of Hea te of De	alth and	Menta		20 05	5 3	34421
Physicia /Medic		1. Decedent's Name (First, Middle Marv L. Pari							Mo	e of Death nth ober	Day 23. 200	Year 05	3. Time of Death 4:49 A M
Examin		4a. Facility Name (If not institution Stella Maris	n, give street and n	umber)			Town, or Lo	ocation of Deal	th		4c. County o	f Death	
Funeral Director		5. Social Security Number 220-03-2856	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	last birthday) Yrs.		r 1 Year If	Under 24 Hrs Hours Min	8. Dat	e of Birth inth, Day, 1	(ear)	9. Birthpl Count	ace (State or Foreign try) /land
show	or	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo				-			10	od. Inside City Limits 1 XYes 2 No
with the M s or 28s-f be notiffi	Director	MD N/A 10e. Street and Number 5603 Summerfie	ald Avenue		timore	10f. Zi	p Code 206			100	g. Citizen of WI	hat Count	try?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. If them 27 is marked other then "naturel" or items 23s or 28s-f show eny injury or other traumatic event, I'm Madical Erem ther must be notified a page.	/ Funeral	11. Marital Status 1 □ Never Married 2 Mar	12. Was De Armed I 1Yes If Yes. 0	cedent Ever in U Forces? 2 X) No		Was Dece	edent of Hispa ecify Cuban, I	anic Origin? (S Mexican, Puer Specify:	Specify Ye to Rican,	s or No-	14. Race	, White, e	
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ally ican	To	John Bowen 19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Addres		Molly Number or R		itz Number,	City or Town, S	itate, Zip	Code)
ges 1 and 2 t of Health If item 27 I		Patricia Sadou 20a. Method of Disposition 1 Veurial 2 Cremation			1211 Place of Dispo cemetery, crem	sition (Na	llamor ime of other place)	e Ct i	#406; Date		onium, N		
permit. Pac Department importent: eny Injury		4 Donation 5 Dother (5 21. Signature of Funeral Service		Gar		2. Name a	nd Address		28/05 al Ho		laltimor 1050 \ Towsor	ork/	
Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	t only one cause or a. EN	t caused the deat each line. D STAGE o (or as a consec	DEMENT		de of dying,	such as cardia	ac or respi	ratory arres	st,		Approximate Interval Between Onset and Death
cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	S	to (or as a consequence of): to (or as a consequence of):									
w requires that the death certific been signed by the attending planted be detached for use as	Physician/Med						pregnancy specify)			23d. Date Mon	ory Day Year		
w requires that it been signed by should be detail	þ	Part II. Other significant conditi	ions contributing to	death but not res	sulting in the u	inderlying	cause given	in Part I.	23				e cause of death? ably 4 TUnknown
The lay ate has page 2	Completed									la. Was an autopsy perform Yes 2	ed? de	ere autor for to core ath? Yes	psy findings available inpletion of cause of
VISION OF VICAL IN Attending Physicien: The r death. sctor: After this certificate his by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	Hospital: 1 [□ Inpatient 2 □ te of Injury onth, Day Year)	ER/Outpatie 28b. Time o Injury		Other: 28c. Injury a Work?	4 N INUISING	Home 5	Resider	nce 6 Othe		v)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could	mined 200. Fld	ce of Injury - At h Iding, etc. (Speci	nome, farm, st	reet, facto	iry, office			cation (Stre ty or Town,		r or Rura	l Route Number,
the Hospl in 24 hour the Funer. pletely fill.	edical	(Check only 2 Medica one)	/	the best of my kn basis of examin anner stated.	owledge, deal ation and/or in	vestigation	n, in my opin	nion, death occ	ce, and du curred at th	ne lime, da	te and place, a	nd due to	the cause(s)
To t with To t	Σ	29b. Signature and title of certific	er			2	9c. License n	1372	5	29	d. Date signed		S Year)
6		30. Name and address of person DR. TARIQ MAH	MOOD 230	O DULANI	Y VALI	EY R	D. TI	MONIUM	, MD	21093	3		
St. Regist		31. Date filed (Month, Day, Year OCT 2 5 20	105 Agra.	. Registrar's Sign	ature	0							

			State of Maryland	d / Depa		lealth and l	Mental Hygi		34422	
Physic /Med	ical	Decedent's Name (First, Middle, Last) A A 4 4a. Facility Name (If not institution, give st	treet and number		QUAR	-	2. Date of Death Month	h Day Yea	05 3:17	
Exami Funera Director		Johns HOPIUMS 6.4 yu.		est birthday). Yrs.		IMME	8. Date of Birth	NA	irthplace (State or Foreign County) YY land	
ıе Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD N/A		Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
th with th	Funeral Director	10e. Street and Number 217 Albemarle Stre	et	•	10f. Zip Code 21202			Dg. Citizen of What JSA	Country?	
ours after dea rel', or Items	b	11. Marital Status 1 Never Married 2 Married 3 Married 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I .	Vas Decedent of H Yes, specify Cubi	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. white	
If yiell I C I C I D-DOOO should be filed within 72 hours after death with the Maryland nd Mental Hygiene marked other then "neturel", or items 23a or 28a-f show matic event, it e Medical Examine the notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Deced (Give life. L Waitre		oation during most of wor d)	rking	Restaurant		
yidild ould be file Mental Hy arked oth	ø	17. Father's Name (First, Middle, Last) Anthony Palmisa	ne (First, Middle, Maiden Sumame) t Giuffre							
MICHE and 2 sh alth and 27 is m er treum		19a. Informant's Name/Relationship (Type Jude Mark Pasquari		Number, City or Town, State, Zip Code)						
ages 1 and of He and of He and of He and of He and you other you other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)		ce) 10/		or Town, State				
Deficilitione, Interpretations permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic ex		21. Signature of Funeral Service License			Name and Addre	ess of Facility		1050 Yor		
Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	/		er the mode of dyin		c or respiratory arre	est,	Approximate Interval Between Onset and Death	
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ite be executed ysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.								
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of decent	у		23d. Date of o	lelivery Day Year			
The law requires that the death the has been signed by the atter sage 2 should be detached for the	by	Part II. Other significant conditions conf	tributing to death but not resul	lting in the ur	nderlying cause gre	en in Part I.			to the cause of death? Probably 4 □Unknown	
The lay	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior t ned? death	autopsy findings available o completion of cause of ?	
JI OI Jing Phy After this funeral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatien 28b. Time of Injury	28c. Injus	ner: 4 ☐ Nursing H	ath (Check only one dome 5 Resider 28d. Describe ho	nce 6 □Other (Sp	pecify)	
	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify))			City or Town	, State)	Rural Route Number,	
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exemin	icien: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the til restigation, in my o	me, date and place opinion, death occu	e, and due to the ca irred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)	
To th Withi To th	M	29b Signature and title of certifier	4/		29c. Licens			d. Date signed (Mo		
5		30. me and address of person who cor	mpleted cause of death (Item	23a) (Type,	Print)	0290	100	COSEL	21, 2005	
S Regis	tate trar	31. Date filed (Morning Dag, Year) 2005	\$2. Registrar's Signatu	ura Ansa	Se la la la la la la la la la la la la la	15/74 JV/K	rie, mu	4424		

State of Maryland / Department of Health and Mental Hygien 0 5 Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 23, Julia Renee Pugh October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 DF 213-04-0811 Director July 10 1983 MD Usual Residence of Decedent iled within 72 hours after deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other then "natural", or items 23a or 28a-f sho other traumatic event. Ite Mudical Examinat must be multified at 1 Yes 2 No Completed by Funeral Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. C 13 Hogarth Circle 21030 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes, Give Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Student Education n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Stanford Pugh III Mary Audrey Beach 2 if itam 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 Mary A. Cramer/Mother 13 Hogarth Circle, Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/27/05 6 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: if any injury or Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 Other (Specify) 21. Signatur 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Bryan W. Clary 23a. Part1 Enter the cisease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in ANOXIA ENCEPHALOPATHY /Medical Due to (or as a consequence of) **Examiner** CARDIO-RESPIRATORY ARREST if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit EIZURE DISORDER **Bud** Due to (or as a consequence of): physicien Physician/Medical CEREBRAL PALSY use as the ettending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform 1 Yes 2 No After this certificate funeral director, pag 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [Homicide Hospitel or 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 10-23-05 D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INTHICUM M.D.
32 Registrar's Signature 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 RICHARD 31. Date filed (Month, Day, Year) State Registrar OCT 2 5 2005

DHMH 17 Rev 1/2001

			For	State of Maryland /	Depa	artment	of H	ealth ar	nd Mer	ntal Hygie	2e() ()		34424	
			1 - Stete Registrar		Cei	tificate	of L	eath		Reg	No.			
	Physici /Medic		Decedent's Name (First, Middle, Last) HOWARD WILBUR							2. Date of Death Month Day Ye. October 22, 200			3. Time of Death 12:17 A ^M	
	Examin	ier	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location of Death					4c. County of Death			
	Funeral		3100 Sunset Lane 5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1		If Under 24	4 Hrs. 8.	Date of Birth (Month, Day, Y			County Diace (State or Foreign	
	Director		178-07-4406	M 2□F 90	Yrs.	Months	Days	Hours			Year) 9. Birthplace (State or Foreign Country) Pennsylvania			
	pun 🛦		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	um or Lo	antion				ar 20,	1.71.)			
	Manyla F sho	ō										'	1 ☐ Yes 2 1 No	
	28a-1	Director	Maryland Baltimore	e County	_Pho	oenix 10f. Zip C	Code			100	. Citizen of	What Cour		
	3a or		3100 Sunet Lane			14/1/19/2		131		,,,,			nuy:	
	death	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decede			n? (Specify	Yes or No-		ce - Americ		
98	or Ita		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1	Tes, specii		Specify:	ruello nica	iii, etc.)	Specif	ck, White,		
ö	hours tural'	ed by	3 Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:			· ·	· A		40		VVLI	nite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or frams 23e or 28a-f show the Madical Examiter frant Le motthed at	Completed	(Specify only highest grade	completed)	(Give	lent's Usual kind of work DO NOT use	done di retired)	uring most o	of working	16	b. Kind of B	usinessino	Justry	
212	d with giene ar tha	Com	Elementary/Secondary (0-12) 12 th	College (1-4or 5+)	Ma	chini	st				Sheet	Meta	a1	
pu	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Health and Mental Hygiene. ortant: If item 27 is marked other then "natural", or Items 23a or 28a-1 show injury or other traumatic event, Ite Madical Examination and injury or other traumatic event, Ite Madical Examinations Items 18.	Be (17. Father's Name (First, Middle, Last)					18. Mother's	s Name (Fi	rst, Middle, Ma.	iden Sumar	710)		
yla	should be ind Mental i markad i imatic ev	2	Robert G. Philli					Id		oung_				
Maryland	d 2 sh th and 7 is n traum		19a. Informant's Name/Relationship (Ty)							oute Number, C				
	Health tam 27 other tr		Russell L. Swartz,	20b. Place	of Dispo	sition <i>(Name</i>	∍ of		Phoen Date	ix, Mar	yland c. Location	2113 City or To	lywn, State	
Baltimore,	permit. Pages 'Department of H Important: If its any injury or ot		1 ☐ Burial 2 X Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or oth	·	1	105.10					
alti	permit. Departm Importa any inju		21. Signature of Function Service Community Serv										Maryland	
<u>m</u>	Dep Imp			n	Mi	tchel	1-Wi	edefe	ld Fu	neral H	Iome,	Inc.	010	
			Martin D. Lawso 23a. Part1. Enter the disease, or complishock, or heart failure. List only on	eations that caused the death. Do	not ent	er the mode	of dying	Sucil as ca	indiac of res	spiratory arrest	aryıa	na 11	imate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Colitis	3								Onset and Death	
	/Medical Examiner		resulting in deality	Due to (or as a consequence	of):									
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):							-		
J	d ansit	Examiner	Cause (Disease or injury that initiated events											
. 1092	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence	of):							-		
	ate be hysici the bu	lical	d											
39 x	that the death certitica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE:	Bc. If yes, outcome of pregnancy										
Вох	atten atten I for u	cian	in the past 12 months?	1 Live birth 2 Fetal death		Ectopic preg						te of delive inth	ry Day Year	
o	the d by the ached	hysi	1 U Yes 2 No	9☐ Unknown		Omer (apoc								
s, P	The law requires that the ste has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions con	_	in the ur	derlying cau	ıse giver	n in Part I.		23e. Did tobac	co use cont	ribute to th	e cause of death?	
ğ	equire en siç ould b		Dement	α						1 🗆 Yes	2 140	3 Proba	ably 4 Unknown	
Record	e law r has be ge 2 sh	Completed								24a. Was an autopsy	24b. \	Were autop	osy findings available	
		Соп								performed 1 Yes 2	2 1	death?	·	
Vital	Physician: this certitics ral director,	Be	25. Was case referred to medical examiner?	ospital:						neck only one)				
	Phys r this aral di	-: To	1 Yes 2 No	1 Inpatient 2 ER/O	utpatient Time of		Other c. Injury a	4 U Nursii		5 Hesidence Describe how i)	
ion	Attanding Ph ir death. actor: After th by the funeral	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work?	s 2∐No			injury decem	00		
Division of	after death after death Diractor: A in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	et, factory, o	office		28f. L	_ocation (Stree City or Town, S	t and Numb	er or Rural	Route Number,	
Ö	ital or A													
	To the Hospital or Attan within 24 hours after deat To tha Funaral Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 2 Medicel Exemin	cien: To the best of my knowledger: On the basis of examination and manner stated.	e, death nd/or inv	occurred at estigation, in	the time n my opi	, date and p nion, death o	place, and o occurred at	due to the cause the time, date	e(s) and ma and place, a	nner as sta and due to	ated. the cause(s)	
	To the within 2 To the complet	2	29b. Signature and tile of certifier	(1) MO			License	_		29d.	Date signed	(Month, E)ay. Year)	
			P 1.001 (um II		D	00	324	15	0	101	24	100	
	10		30. Name and address of person who cor											
	Sta	te	Mark Lamos, 9 Sch	illing Road, Co	ckey	svill	e, P	laryla	nd 21	030				
*	Registr	_	OCT 2 5 200	ailling Road, Co 32. Registrar's Signature	S. Comments	3451								

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland / D	epa <i>Cen</i>	rtment of He tificate of D	ealth and leath		ie2e0 0 5	34425			
	100	· ·	Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death			
-	Physici /Medic		William Edward Pea	cher Jr				Month	Day Yes				
	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or L	ocation of Deat		4c. County of D				
4			Washington County	Hospital		Hagersto	wn		Washington				
	Funeral	Ĭ.	5. Social Security Number 6. Sex	7. Age (In yrs. last birt			If Under 24 Hrs Hours Min.		Year) 9. I	Birthplace (State or Foreign Country)			
S.A.	Director		217-10-0040	M 2□F 82	rs.			Mar 3,		aryland			
	land II		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Loc	ation				10d. Inside City Limits			
	Mary	Po	MD Washingto	ир На	707	stown				1 ☐ Yes 2 ☐ No			
	10 10 10 10 10 10 10 10 10 10 10 10 10 1	rec	10e. Street and Number		gers	10f. Zip Code		1	0g. Citizen of What				
	3a o	Funeral Director	11923 Wesley Driv	re			21742		USA				
	death	ner		. Was Decedent Ever in U.S.	13. W	as Decedent of Hisp	panic Origin? (S	Specify Yes or No-		merican Indian,			
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or iteme 23e or 28e-f show the Medical Evariation must be invitibled.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 142-45		Yes, specify Cuban,	Specify:	to Hican, etc.)	Black, W				
Ö	2 hor	Completed	15. Decedent's Educa	ition 16a.	Decede	ent's Usual Occupati	ion	della m	16b. Kind of Busine	ss/Industry			
215	thin 7 9.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ind of work done du O NOT use retired)	ring most of wo	rking					
2	ad wit	Con	12	5+	te	eacher			educati	on			
nd	al Hy	Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Na	me (First, Middle, I	Maiden Sumame)				
yla	Duld to Ment arked	ဥ	William Edward Pea				Ethe1	Sarah Mu	rray				
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (Type			Address (Street an			•	e, Zip Code)			
	s 1 and 2 and 4 an		Marjorie Peacher/s 20a. Method of Disposition	20b. Place of		Wesley I	rive Ha						
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other traumatic event, the Mudical Event in at must be rediffied at ADGE.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☑ Donation 5 ☐ Other (Specify)	20c. Location - City	or rown, State								
Balt	permit. Depart Import any inj		21. Signature of Funeral) ervice Licensee Ronald S. W	ide Director	St.	Name and Address ate Anator	my Boar	d 655 W.	Baltimore	Street			
	age to be	Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. A											
	Physician		Immediate Cause (Final disease or condition	BILATERAL	211	IMUNG	RY G	MRDILL	c	Interval Between Onset and Death			
	/Medical		resulting in death)	Due to (or as a consequence of			11 1	7 113 0 0 0 0	3				
*	Examiner		Sequentially list conditions	ASPIRATIO	M	PMEU	MOM	IA					
	p ii	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of		C . C . C	_ , _						
	ecute and trans	Examiner	that initiated events c. resulting in death) Last	PULMOHAF Due to (or as a consequence of		FIBRU	215						
60,	icate be executed physician and s the burial-transit	a E		Due to (or as a consequence of	н):								
68760,	physicate the last	edical											
_		/Me	IF FEMALE: 230	c. If yes, outcome of pregnancy			23d. Date of	dolayon					
Box	w requires that the death cert been signed by the attendin should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year			
P.O.	the c	hysi	9 Unknown	9□ Unknown									
	s that	y P	Part II. Other significant conditions contr						acco use contribute	to the cause of death?			
ğ	quire an sig uld b	Completed by	COMGESTIVE ME	AFT FAILUR	1,3	12HI HON	IUH D	۶β 1 □ Ye	s 2 No 3	Frobably 4 Unknown			
O O	aw re	plet	-EMDENT DIA	BETES MELLI	TU	S MYPO	THYFI	24a. Was a		autopsy findings available			
Ĕ	The I	E O	THROMBOWY-	FIRS & DT				perform	prior death				
ita	ien: rtifice stor, p	Be C	25. Was case referred to medical	0-1-0-(17)		2	26. Place of De	ath (Check only on					
>	nyeic nis ce direc	To	examiner? 1 Yes 2 No	spital: 1 Impatient 2 ER/Out	patient	3 DOA Other:	4 Nursing H	lome 5 ☐ Reside	nce 6 Other (S	pecify)			
0	ng Pl		27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury 28b. T (Month, Day Year) In	ime of	28c. Injury a Work?	it	28d. Describe ho	w injury occurred				
sio	tendi eath. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be			M 1 Ye	s 2 No						
Division of Vital Records,	s after de bill Direct	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, stre	et, factory, office		28f. Location (St. City or Town		Rural Route Number,			
	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowledge, r: On the basis of examination and and manner stated.	death Vor inve	occurred at the time, estigation, in my opin	, date and place nion, death occu	a, and due to the caurred at the time, da	use(s) and manner ate and place, and c	as stated. lue to the cause(s)			
	To the To the Comp	W	29b. Signature and title of certifier			29c. License r	number	29	9d. Date signed (Mo	onth, Day, Year)			
			1 (100)	- MD		D 6	232"	7	10/19/	05			
			30. Name and address of person who com	pleted cause of death (Item 23a) (Туре, Р	Print)	11						
			Dy Banca	368 32 Registrar's Signature	nil	l St	Ang.	Md 2	1740				
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	all B	/						
X_{ij}	Registr	ar	OCT 2 5 200	Deleteras Dr	400	456							

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>		of Health ai <i>of Death</i>		giene (15	34426
			Decedent's Name (First, Middle,	_ast)			-	2. Date of De		Van	3. Time of Death
	Physici /Medio		Eva C. Romar					Octobe	22	2005	12:35P M
7	Examir	ner	4a. Facility Name (If not institution,			-	own, or Location of	Death		ty of Death	
			Holy Cross Rehab 5. Social Security Number 6		ing Center Age (In yrs. last birthday		nsville Year If Under 24	4 Hrs 0 Date - 4 Di		gomery	<u></u>
	Funeral Director		171-01-0460	1□M 2ÅF	95 Yrs.		Days Hours	4 Hrs. 8. Date of Bir (Month, Da July 20	y, Year)	Cour	place <i>(State or Foreign</i> ntry) Sylvania
			Usual Residence of Decedent					July 20	, 1710	r Cillis	syrvania
	show	_	10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
	8a-f	ecto	Maryland Howa	rd	Columb						1 ☐ Yes 2 📆 No
	with ti	吉	10e. Street and Number 9112 Flamepool	Way		10f. Zip Ci	ode .045		10g. Citizen of U.S.A		ntry?
	filed within 72 hours after death with the Maryland Hygiene ther than "naturel", or Itema 23a or 28a-1 show thit, The Medical Exartinger mast by notified at	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S. 13			n? (Specify Yes or No		ice - Americ	can Indian
ယ	w Item	Fun	1 ☐ Never Married 2 ☐ Married	Armed Force	es?	If Yes, specify	Cuban, Mexican,	Puerto Rican, etc.)		ack, White,	
93	rel', c	Completed by	3X Widowed 4 □ Divorced	If Yes, Give Year or Date	es:	1 ☐ Yes 25	No Specify:		Speci	fy: Wh:	ite
5-0	72 h "natu	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	edent's Usual (Occupation done during most of retired)	of working	16b. Kind of I	3usiness/In	idustry
121	within ane. then	m m	Elementary/Secondary (0-12)	College (1-4	or 5+)	usewife			Own	Home	
d 2	Hygie ther ant.		17. Father's Name (First, Middle, La	st)	110			s Name (First, Middle			
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 le marked other than "traumatic event, the Mes	To Be	Calvin Daubert					beth Sauer		,	
ary	shou ind M mar umat		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (S	Street and Number	or Rural Route Numb	er, City or Town	ı, State, Ziç	Code)
Σ,	and 2 alth a 127 le ar trau		Betty J. Rupp	(Daughte	r) 9112	F1amep	ool Way	Columbia,	Mary1a	ınd 21	∟045
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner mat be notified at once.		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		20b. Place of Disp Berks Cot Memorial	osition (Name matory or othe Garden	of er place)	Date -26-2005	^{20c.} Location Maiden Pennsyl	Creek Vania	own, State TWp.,
Balti	permit. Departn Imports any inju		21. Signatule of Funeral Service us	ensee	W	2. Name and A	Address of Facility uneral H	ome of Cat venue Cato	onsvill nsville	.e, In	nc. 21228
			23a. Part1. Enter the disease or co shock, or heart failure. Uset or	mplications that cau							Approximate Interval Between
惺	Pnysician	2 15	Immediate Cause (Final disease or condition	50	nile o	len	ontia				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	1	~	,		- 4	, 2001
	Lxammer	_	Sequentially list conditions,	b. 1 PF	as a consequence of):	art	erial	disea	5-6		Lyeur
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- Dus to (or	as a consequence or):						7
<u>,</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					-	
8760,	cate be executed physician and the burial-transit	dlcall		d.							
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		⊒Ectopic preg	nancv			ate of delive	•
	e dea	sici	in the past 12 months? 1 Yes 2 No		t at time of death 5	Other (speci			М	onth	Day Year
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Vital Records,	ires tha signed d be dei	i by	Takin other signmean contactors	continuating to deat	in but not resulting in the t	andenying caus	sa given in raiti.	1 🗆 `			pably 4 Tunknown
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Re	he lav	Completed						24a. Was autop perfo		prior to cor death?	ppsy findings available impletion of cause of
ta		e Co	25. Was case referred to medical				OC Diago	1 Yes		1 🗆 Yes	2 No
5	Phyaician; r this certific ral director,	O B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	atient 2 ☐ ER/Outpatie	nt 3 DOA		ing Home 5 ☐ Resid		hor (Specif	5.1
of	ding Phy h. After thi funeral o	n: T	27. Manner of Death	28a. Date of I			. Injury at Work?	28d. Describe I			77
io	Attendin death. ctor: Aft y the fur	atlo	1 Natural 5 Pending 2 Accident investigat	ion	Day real/ Injury	М	1 ☐ Yes 2 ☐ No				
Division	I or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	a 280. Place of	Injury - At home, farm, st, etc. (Specify)	reet, factory, o	ffice	28f. Location (S City or Tov		ber or Rura	al Route Number,
Q	ital o rrs aff raf Di										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1X Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basi and manner	est of my knowledge, dea s of examination and/or in stated.	th occurred at the occurred at	the time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as st and due to	tated. the cause(s)
	o the	Me	29b. Signame and title of certifier		olulos.	29c. L	icense number		29d. Date signe	ed (Month,	Day, Year)
		/	> Coul at 1:	4		D	4323	7	Sictobo	2-24	1,2005
1	2		30. Name and address of person wh	o completed cause of	of death (Item 23a) (Type	4.	(1-0)	1	(0)		
1			Dr. Paul Armstro	•	14201 Laure	,	Dr. Laur	el, Maryla	nd 2070	7	
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	Registr	ar	OCT 2 5 2	005	istrar's signature	A CONTRACTOR OF THE PARTY OF TH					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 05 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician M 42H Octobee 21 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** t'more INAI If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F -5906 Vrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If is marked other then "neturel", or iteme 23s or 28s-f eho: traumatic event, the Mackes Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director Maryland 10e. Street and Number more 10g. Citizen of What Country? 10f. Zip Code 12 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2 XNo f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental Hitant: If item 27 is marked off Be ဂ္ (Sister) t's Name/Relationship (Type, P nt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 is or other tra SCOWN Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signarun of Funeral Service Licensee 22. Name and Address of Facility enter the disease, or complications that caused the death. or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 00 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 ☐ Unknowh Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Tension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 2 0 NO 1 Yes 1 Yes After this certifice funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 21 NO 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Selaturai 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SICIAN D0054228 oclober who completed cause of death (Item 23a) (Type, Print) and address of p W. Belvedere Ave BA Himore, MO 21215 JR,MD240

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2e 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 101 001 /Medical cility Name, If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ING **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 11. Marital Status Was Decedent Ever in U.S. nt of Hispanic Origin? (Specify Yes or No-Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: Specify: "naturel", 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during 16b. Kind of Business/Industr permit. Pages 1 and 2 should be filad within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nany injury or other treumatic event, "the Med ONCE. ite DO NOT use retired econdary (0-12) College (1-4or 5+) ame (First, Middle, Last) 19b. Mailing Address (Street and (ONN. 20a. Method of Disposition ₩Burial 2 Cremation 3 □Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): use as the burial-transit that initiated events resulting in death) Last the attending physician and had for use as the burial-tran Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Y*e*ar Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ eq cate has baan sig , page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 21 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 일 1 ☐ Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Certification; 28d. Describe how injury occurred After 1 Natural 2 Accident s after dea. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours an To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 4734 66 38. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 05 1 - Stata Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 7:02 P OCTOBER 2005 Dorothy Dusterhoff Roskott /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number). Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 ▼F Yrs MD Dec. 28 1919 85 218-01-7473 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ehow. in than "naturel", or iteme 23a or 28a-f ehov the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD **Baltimore** Phoenix 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 49 Club View Lane 21131 death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after d al Hygiene. I other than "naturel", or Item 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: white þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Irene Minnie Krauk Carl August Dusterhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 96 Mill Creek Ct., Charlottesville, VA 22902 Carl W. Roskott/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/27/05 1 Dopation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21093 Sign of an ervice Licensee Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Lowell M. Lemmon Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical CHOLANGIOHEFATITIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine PANCREATIC CANCER The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day Year signed by the atte 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown HYPOGLYCEMIA should l Completed 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death? certificate has b lirector, page 2 si 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗍 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide To une ...
within 24 hours after
To the Funerel Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier chla m.D D 41410 2005 マスル 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 JOGINDER P. MEHTA, 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 0534430 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ROTH 7:05 AM SAHUEL 18 LEONARD, OCT 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MEDICAL CENTER BALTIHORE BALTIMORE n/a Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Note: 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□ F 88 217-01-2311 Director PÃ Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 3☐ No Director MD Baltimore Lutherville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 Brooklandwood Rd. 21093 USA Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Itam 27 Is marked other than "naturel", or Itel 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 143-146 Specify: white 3 Widowed 4 Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Compl Elementary/Secondary (0-12) College (1-4or 5+) 12 Ship Chandler Shipping n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nathan Roth Rose Goldberg 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Roth/wife 1008 Brooklandwood Rd., Lutherville, MD 21093 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or once. Garrison Forest Vet. Cem. 10/25/05 Garrison Forest, MD 21. Signature of Funeral Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Hagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner FEP415 Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed RENAL FAILURE Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a o 9 Unknown 9 Unknown Records, P. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTATIC PROSTATE CANCER 1 □ Yes 2 □ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25 No of Vital 1 Yes 2 No 1 Tes director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2XNo Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide filled in within 24 hours a To the Funerel L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P17643 H.D. 18, 2005 of person who completed cause of death (Item 23a) (Type, Print) GREENE ST. BALTIMORE HD WEN-YEE TSAI H.D. 10N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Marylan	d / Depa	artment o	f Health a of Death		Reg. No.	5 3	34431		
8	Physici	an	1. Decedent's Name (First, Middle, Last) Patricia Ellen Ro					2. Date of D	Day	O5	3. Time of Death 2045 M		
***	/Medic Examir		4a. Facility Name (If not institution, give s	street and number)		- 11	n, or Location o	OCT of Death	2 20 05 2045 M 4c. County of Death N/A				
2:	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 64	last birthday) Yrs.	If Under 1 Ye Months Da	ar ir Under	Min. 8. Date of B	Date of Birth 9. Birthplace (State or				
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10	d. Inside City Limits		
	Mary a-f sho	ctor	MD Balti	more		Arbutu	s				1 ☐ Yes 2X No		
	with the	Funeral Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of V		,		
	ns 23e	eral	1330 Stevens Aven	12. Was Decedent Ever in U.	S. 13.	Was Decedent	21227 of Hispanic Orio	gin? (Specify Yes or N		ed St			
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Exans ar must be restified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		If Yes, specify C	Cuban, Mexican	, Puerto Rican, etc.)		k, White, et			
2-0	"natur	leted	15. Decedent's Edu (Specify only highest grade	cation a completed)	(Give	dent's Usual Oc kind of work do	ne during most	t of working	16b. Kind of Bu	ısiness/Indu	ustry		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinat must be redified at once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	DO NOT use re Office			Ra	ilroa	d Co.		
		BeC	17. Father's Name (First, Middle, Last)					r's Name (First, Middl					
Maryland		To	Charles Walter Ro		40h M-10			osalie Sow					
Ma			19a. Informant's Name/Relationship (Ty) Michael Noble,	Son				Arbutus,		State, Zip C	Zode)		
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 R		20c. Location - City or Town, State								
ij			4 Donation 5 Other (Specify)	5 Balti									
Bal	Departing Important Information Informatio		1. Signature of Fun ral Service License	CONTRA S				y Ambrose F					
1			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death	n. Do not ent	er the mode of	dying, such as	ring Rd.,	Arbutus, arrest,	/	122/ Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	1)	lun	noni	a.			1	Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):								
		Jer	Sequentially list conditions, if any, leading to immediate). Due to (or as a consequ	uence of):								
V	ecuted transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
38760,	cate be executed physicien and the burial-transit	al Ex	resulting in death) cast	Due to (or as a consequ	uence of):								
687		edical											
30X	tth cert tendin or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	incy			e of delivery	•					
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۳.	s that t ned by e detac	by Ph	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use contr	ibute to the	cause of death?		
Division of Vital Records,	w require been sig should b	ted b	Diabetes					152	Yes 2□No	3 🗌 Probab	bly 4 Unknown		
Ş Ş	e faw r has be	Completed	COPD	1 1 1 1 1 1				24a. Wa	opsy p	prior to comp	sy findings available pletion of cause of		
<u>a</u>	Physician: The lav this certificete has al director, page 2	e Cor	25. Was case referre to medical	il lufecti	m.			1 ☐ Yes	2 No 1	leath?	: D-160		
⋛	ysicia is cert directe	To Be	examiner?	lospital: 1 Impatient 2	ER/Outpatien	t 3 DOA	Other	of Death (Check only rsing Home 5 ☐ Res		er (Specify)			
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<u>></u>	al or A s after st Dire	Certification:	4 Homicide determined	building, etc. (Specify)	eet, ractory, om	06	City or To	own, State)	si Oi Muiai i	HODIE NUMBER,		
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours attendesth. To the Funers! Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or in	occurred at the restigation, in m	a time, date and ny opinion, deat	place, and due to the th occurred at the time	cause(s) and ma , date and place, a	nner as stat ind due to tl	ted. he cause(s)		
•	To the within To the comp	×	29b. Signature and title of certifier	$M \cdot D$,	29c. Lica 13	cg2	02033	29d. Date signed	(Month, De	ay, Year)		
	5		30. Name and address of person who co	mpleted cause of death (Item 1312 - Old Co	123a) (Type,	Print) Apt	2A, P	02033	MD 2	120	8		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 5 200	32 Registrar's Signa	mie mie	West !					0		

MOSE, PATRICIA

State of Maryland / Department of Health and Mental Hygiene 34432 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robertson Herman Ray 02:45 AM 05 10 2 2 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bultmore Bultmore Sinai 40 5. Social Security Number 11more if Under 1 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1**X** M 2□ F Months Hours 90 Days Director none MARYLAND 10-22 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic avant. The Mudical Examiner roust by notified at **Baltimore** Maryland Woodstock Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 United States of America 3116 Persimmon Tree Court or Items 23e 21163 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Im 27 Is marked other than "natural", or Itel Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Omar O. Robertson Courtney R. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any injury or other trau once. Omar O. Robertson (Father) 3116 Persimmon Tree Court, Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mt.Comfort Crematory Oct. 24, 2005 Alexandria, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Rd., Randallstown, MD 21133-4784 MO0333 23a. Roll. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician 90 minut disease or condition resulting in death) Due to (or as a consequence of): prematunt /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ig physician and as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical esn 9 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown 9 Unknown \$ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably page 2 should Be Completed 2 X No 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. within 2 29b. Signature and title of certified 29c. License number 29d. Date signed, (Month, Day, Year) 30. Name and address of person ho completed cause of death (Item 23a) (Type, but) mD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 5 2005 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			For State	State of Maryla				Mental Hy	giene n	05	21.1.21.
	1. Sup. 1. 1.		State Registrar 1. Decedent's Name (First, Middle, Las	a)	Cert	ificate of L	Death	100.00	Heg. No.	7 0	34434
	Physic	an	(1)		idSole			2. Date of De Month	. Dav	Year	3. Time of Death
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×	- Funeral		5. Social Security Number 6. Se	7. Age (In yr:	s. last birthday)	If Under 1 Year	II Under 24 Hr		rth Years	9. Birthpl	ace (State or Foreign
400	Director		183-54-2098	^{™ 2□ F} 32	Yrs.	Months Days	Hours Mir	Jan. 2	0, 1973	Coun	nsylvania
	and *		Usual Residence of Decedent 10a, State 10b, County	10c.0	City, Town or Loca	ation					
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	ier death Itema 2	ner	11. Marital Status	12. Was Decedent Ever in	U.S. 13. W	as Decedent of Hi Yes, specify Cubar		Specify Yes or No		e - America	an Indian,
36	ुं व	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Yes, specify Cubai □Yes 3/ □No	n, Mexican, Pue Specify:	rto Rican, etc.)	Specifi Specifi	ck, White, e	itc.
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Mar	12 sh h and 7 is m raum	12 F	19a. Informant's Name/Relationship (T)			Address (Street a					
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nor	ages int of t: if it		1 XBurial 2 ☐ Cremation 3 ☐ I			tion (Name of tory or other place		22/05	20c. Location -	•	
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B	permi Depa Impo any is		Veal J.	lang .	Ru	ck Towsor	n Funera	al Home,	Inc. To	50 Yo: wson,	rk Road Md.21204
樂			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea ne cause on each line.	ath. Do not enter				rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Enteroca		Bact	ecemia]	Month
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	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
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Вох	death certifi e attending I ad for use as	clan	in the past 12 months?	23c. If yes, outcome of pregr 1□Live birth 2□Fet 4□Pregnant at time of	al death 3 □E	ctopic pregnancy Other (specify)			23d. Dat Moi	e ol deliven	/ Day Year
P.O.	0 0 0	Physician/M	1 Yes 2 No	9□ Unknown	3 C	otter (specify)					
σ,	The law requires that the ste has been signed by th page 2 should be detache	by P	Part II. Dther significent conditions co	ntributing to death but not re	sulting in the unde	erlying cause giver	n in Part I.	23e. Did to	obacco use contr	ribute to the	cause of death?
Records,	en sig							1 🗆 🗅	Yes 2 No	3 🗌 Probal	bly 4 🗆 Unknown
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of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Janaitali				ath Check only o	ne		
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Ö	tal or s afte al Dir	Certification;	4 Homicide	building, etc. (Speci	fy)			City or Tou	vn, State)		
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	withii To th	ž	29b. Signature and title ol certifier			29c. License	number		29d. Date signed	(Month, Da	ay, Year)
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			30. Name and address of person who co		m 23a) (Type, Pri	AU917 Stend S					
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Second Second Property Sec		Examin	er											,		
Total State Total County Total				5. Social Security Number	6. Sex	7. Age (In yrs.					Min.	. Date of Birth (Month, Day ct. 19	Year) 1925		ountry)	n
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Registrar OCT 2 5 2005				31. Date filed (Month, Day, Year)	2005 /	Registrar's Sign	ture	ales								

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			1 - For State Registrar	State of Maryland	∣ / Depa <i>Cei</i>	artmen <i>rtificat</i>	it of He e of E	ealth and Death	Mental Hy	gien	000	344	36
	Physici	an	1. Decedent's Name (First, Middle, Las.						2. Date of De	aath Da	v Year	3. Time of	Death
	Physici /Medio		Mary B. Sei						Octobe:	r 18	8 2005		5A M
	Examir	er	4a. Facility Name (If not institution, give Sulmerford Assis					Location of Deat	h		County of Deat		
	Funeral		5. Social Security Number 6. Se		st birthday)	If Under	ersto 1 Year	If Under 24 Hrs		rth	ashingto	DII hplace (State o untry)	r Foreign
	Director		218-07-5386	□M 2 X □F 87	Yrs.	Months	Days	Hours Min.	Nov. 1		17 Mary	untry) Jand	
	pug 🔉		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation						10d. Inside Cit	te Limita
	Maryli 1 sho	ō	Maryland Washing		agers							1 🗆 Yes	-
	1 the 1	Director	10e. Street and Number		agero	10f. Zip	Code			10g. Ci	tizen of What Co	untry?	
	h with	a D	10116 Sharpsburg	Pike			217	40		U	.S.A.	•	
036	d within 72 hours after death with the Maryland liene. r then "netural", or tame 23a or 28a-1 show I'n Medical Evania or must be confilled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Dece f Yes, spe I Yes		panic Origin? (S , Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	o-	14. Race - Ame Black, White Specify: White	e, etc.	
Maryland 21215-0036	within ane. then	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			lent's Usus kind of wo DO NOT u	erk done du se retired)	ion uring most of wo	rking		(ind of Business/	Industry	
2	Hygie other	0	17. Father's Name (First, Middle, Last)		Home	make	-	18. Mother's Nar	ne (First, Middle		n Home		
lan	0 0 0 0	To B	John Koubek					Antony	Prucha				
lary	2 should and Men ie marke aumatic		19a. Informant's Name/Relationship (T	/pe, Print)	19b. Mailin	g Address	(Street a	nd Number or Ru	ıral Route Numb	er, City	or Town, State, 2	Zip Code)	
≥,	is 1 and 2 of Heelth a item 27 ie other trai		Charles O. Seiser		5005			Road T			ryland 2		
Baltimore,	Pages 1 ament of Hee ant: If item ury or othe		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		natory`or o	other place emete	ry 10-2		Balt	ocation - City or	aryland	l
Balt	permit. Page Department important: if eny injury or		21. Signature of Funeral Service Licente	Valoreste	₩i 16	Name ar tzke 30 E	Fune dmond	of Facility ral Hom son Ave	e of Cat Catons	tonsy svil	ville, I le, Mary	inc. land 21	1228
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. ne cause on each line. aQ VN En-	Do not ente	er the mod	de of dying	such as cardia	or respiratory a	rrest,		Approximate Interval Bety Onset and D	ween
68760,	Examine and buysicien and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	Stul	n a.v	Ac	cidli	a +			(84	
P.O. Box 6	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	eath 3	Ectopic pr					23d. Date of deli Month		'ear
	w requires that the de been signed by the a should be detached f	ρ	Part II. Other significant conditions co	ntributing to death but not result	ing in the ur	nderlying c	ause giver	in Part I.			use contribute to ☐ No 3 ☐ Pro	_	
Division of Vital Records,	The lar	Completed							24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to death?	topsy findings a completion of ca	ivailable iuse of
₹	iding Physician: T th. : After this certificet funeral director, ps	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 🗷 E	R/Cutpati-n	D 3□ DC	Othor		th Check only o		6 □Other (Spec		
0	9 Phy erthi		27. Manner of Death	1	8b. Time of		28c. Injury		28d. Describe			ary)	
jo	Attending r death. actor: After by the fune	atlo	1 √Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Bay rear)	Injury	М		s 2 □No					
<u>Si</u>	tal or Attendests after death al Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factor	y, office		28f. Location (City or To	Street an wn, State	nd Number or Ru a)	ral Route Numb	⊃e <i>r</i> ,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	one) 2 Medical Exam	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred	at the time , in my opi	n, date and place nion, death occu	, and due to the rred at the time,	date and	d place, and due	to the cause(s)	
	To the within To the comple	Σ	29b. Signature and title of certifier				. License				te signed (Month	, Day, Year)	
	9		me				1) (2	323			19/5		
V	5		30. Name and address of person who c	ompleted cause of death (Item 2			(+	HAM	R(TA.	n. Pr	0 2/7	60	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		Je ne	~ <i> </i>	7/17 410	10W)	V ///	1 01/	70	
	Registr		OCT 9 E 2005	French 1	A Property of								

		State of Maryland / Department of Health and M I = State Registral Amend Item 24a per verbal G848 ellin 25 05 beath		giene 2005	34437
Physic	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year	
/Medi Examir	cal	DENISE GLORIA SCOTT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Octobe	4c. County of Dea	<u> </u>
Examir	ier	Sinai Hospital of Baltimore Baltimore Ci	ty	/	U/A
Funeral Director		5. Social Security Number 6. Sex 1 \(\text{Months} \) 1 \(8. Date of Birth (Month, Day APRIL 2	Year) C	rthplace (State or Foreign ountry) 1 ARY LAW
land]	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		,	10d. Inside City Limits
Marylan a-f show	tor	MARYLAND NIA BALTIMORE	E C17	V	1 Yes 2 □ No
with the Marylar s or 28s-f show	Director	10e. Street and Number	1	Og. Citizen of What C	ountry?
sath w		55/3 BELLE AVENUE 2/2/3 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe		14. Race - Am	
72 hours after death with the Maryland natural, or items 23e or 28e-f show Jicel Examiner, and be notified at	by Funeral	11. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2 Married 1 Married 2 Married 1 Married 2 Married 3 Widowed 4 Divorced 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Ma	Rican, etc.)	Black, Whi	
72 hoi natura	sted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ına	16b. Kind of Business	s/Industry
9 - 2	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Paris	
be filed within stal Hygiene. Id other then event, the man	e Co	17. Father's Name (First, Middle, Last) 18. Mother's Name			UTBANK
d ia b	To Be	MCKINLEY SCOTT GLOR		12	EADS
s 1 and 2 should f Health and Mer Item 27 le merke other treumetic		19a. Informant's Name/Relation Lip (Type, Print) 19b. Mailing Address (Street and Number or Rura			
ges 1 and 2 it of Health If Item 27 I		GLORIA SCOTT (MOTHER) 55/3 VIELLE AV	E. XJA	LTIMORE,	HD 2/2/5 Town, State
00-		1 ⊠Burial 2 □ Cremation 3 □ Removal from State Cemetery, crematory, or other place)			4
permit. Pag Department Important: I eny injury c		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	_	-	IN MARYLAND
Depre survey		Detrech N. Williams 5955 94 Hill		BALTO, M	NERAL HOME
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician	: 10	Immediate Cause (Final disease or condition AIDS			Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate b. Primary CNS Lymphoma Due to (or as a consequence of).			
uted	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
ate be shysici the bu	dical	d			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		224 Dave of de	46
attene attene for us	Physician/Me	in the past 12 months?		23d. Date of de Month	Day Year
that the de ed by the detached	hysl	1 ☐ Yes 2 1 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
res tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute t	
v require been si			1 🗆 Ye	es 2 No 3 P	robably 4 dinknown
e aw I	Completed		24a. Was a autops	sy prior to	utopsy findings available completion of cause of
n: The ficate r, pag				No 1 Ye	s 20 No
Physician: The law r this certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No 1 □ Yes 2 □ No Cther: 4 □ Nursing Ho.		ne) ence 6 ∐Other (Spe	noth)
g Phy g Phy ler this		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	ecily)
ending F eath. or: After he funer	atlo	2 Accident investigation M 1 Yes 2 No			
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	treet and Number or R n, State)	Bural Route Number,
pital Durs a lerel [29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the o	auso(s) and manner a	c stated
• Hos	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	red at the time, d	ate and place, and du	e to the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mon	
010		Kazi A. Zaman, M.D RES-000	0	October	20,2005
PS V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAZI A. ZAMAN, M.D. SINAI HOSPITAL OF	- RAIT	IMPRE	
All to St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	13174		
Regist		DCT 2 5 2005 Report At Specific			
DHMH 17 Rev 1/2	2001	The families to			
		ORIGINAL			

DHMH 17 Rev 1/2001

Patient known as Demise G. Scott

		•	For State	State of Mar	yland / Depa <i>Cel</i>	artment of He rtificate of D			iene .g. No. 005	34438
			Registrar 1. Decedent's Name (First, Middle, Last)	-		tinoato or E	700111	2. Date of Deat	h	3. Time of Death
	Physici		Gussic F	× 51-	WAYT			10.18.	2005 Year	8:12 PM
	/Medio Examin		4a. Facility Name (If not institution, give s		W HY I	4b. City, Town, or	Location of Death	10 10	4c. County of Deat	
	LXaijiii	<u> </u>	1200 SEMINOLE	AVENUE		BALTIMO	RE		NA	
	Funeral		5. Social Security Number 6. Sex		in yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	hplace (State or Foreign untry) SC
	Director		713.26.6030	M 200 F 65	Yrs.			11.05.10	939	30
	and	-	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ठ्	mo Na	E	BALTIMORI	E				1 🗗 Yes 2 🗆 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	untry?
	th witi		1200 SEMINDLE	AVENUE		212	29		USA	
	ams erm	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	ours after death with the Marylan ral', or Itams 23a or 28a-f show Evaminal must be the tillied at	by Fu	1 Never Married 2 Married	1 Yes 2 No If Yes, Give	i	1 ☐ Yes 2 🗷 No	Specify:		Specify: 2)	ACK
0	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show ideal Examinat must be ricilified at	ed b	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occupa	tion		16b. Kind of Business/	
15	in 72 n "na Neals	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done di DO NOT use retired)	uring most of work	ring		,
21215-0036	filed within Hygiene. other than "	Completed	12 TH GRADE	N A	HC	MEMAKE	2		DOMESTI	C
pu	ed a S	Be	17. Father's Name (First, Middle, Last)				/	e (First, Middle, N		
Maryland	Mer Mer arke	40	LEROY WILLIAMS 19a. Informant's Name/Relationship (Ty,	no Print)	10h Mailir	o Address /Street a		SONAPAR	City or Town, State, 2	Tin Code)
Z	d 2 sho		JAMES STEWART	. SR	1200	SEMINOL		BALTIM		21229
ē,	s 1 and 3 if Health itam 27 other tra		20a. Method of Disposition	, 5,10	20b. Place of Dispo	the property of the same of th		7	20c. Location - City or	Town, State
E S	0 0 = =	j	1 ■ Burial 2 □ Cremation 3 □ R 1 ■ Donation 5 □ Other (Specify)	temoval from State	WESTERN		10.2	2.05	BALTO. MD	
Baltimore,	arth orta injt		21. Signature of Funeral Service Licens	Pap	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Name and Address				
<u>m</u>	Dep fimp any		Vangtin C		51	51 BALTO 1	NATU PIKI	E, BALTO.	MD 21229	
			23a. Part1. Enter the disease, or compliant shock, or heart failure. List only or	ications that caused the ne cause on each line.	e death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)	MYC	CARI	MAL	WEA	RCTTOL	, TROBAL	LE 2MIN
	/Medical Examiner		resulting in dealiny	Due to (or as a o	consequence of):		-11			20 YEARC
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence of):	THE	-151 1	112FA	>6	20 18/4
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	sician and burial-transit		resulting in death) Last	Due to (or as a o					i i	
8760	cate be ohysici the bu	ā			consequence or):					
9	S P S	유		d	consequence ory:					
~	entif ling e a	Medical	IF FEMALE:	J						
Вох	ath certif attending for use a	lan/Medic	23b. Was decedent pregnant	d	pregnancy	Ectopic pregnancy			23d. Date of del	ivery Day Year
.O. Box	the death certifica y the attending pt ched for use as the	ysiclan/Medic			pregnancy	Ectopic pregnancy Other (specify)				•
P.O.	s that the death certif ned by the attending e detached for use a	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	pregnancy □ Fetal death 3 ☐ ne of death 5 ☐	Other (specify)	n in Part I.	23a. Did tok		Day Year
s, P.O.	quires that the death certit on signed by the attending uld be detached for use a	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 29 No 9 Unknown	1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	pregnancy □ Fetal death 3 ☐ ne of death 5 ☐	Other (specify)	n in Part I.		Month	Day Year the cause of death?
s, P.O.	aw requires that the death certit ss been signed by the attending 2 should be detached for use a	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 29 No 9 Unknown	1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	pregnancy □ Fetal death 3 ☐ ne of death 5 ☐	Other (specify)	n in Part I.	1 □ Ye 24a. Was a	Month pacco use contribute to as 2 \(\text{No} \) No 3 \(\text{SPr} \)	Day Year the cause of death? obably 4 Unknown
Records, P.O.	iaw requires that the cas been signed by the 2 should be detached	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 29 No 9 Unknown	1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	pregnancy Fetal death 3 ne of death 5 not resulting in the u	Other (specify)	n in Part I.	1 ☐ Ye 24a. Was al autops perform	Month pacco use contribute to as 2 □ No 3 Pr	the cause of death? obably 4 Unknown topsy findings available completion of cause of
Records, P.O.	cian; The law requires that the death certificate has been signed by the attending actor, page 2 should be detached for use a	Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 25 No 9 Unknown Part II. Other significant conditions cor DRES DRAGE 25. Was case referred to medical examiner?	1 Live birth 2 4 Pregnant at tin 9 Unknown	pregnancy Fetal death 3 ne of death 5 not resulting in the u	Other (specify)	26. Place of Dear	1 ☐ Ye 24a. Was al autops perform	Month pacco use contribute to as 2 No 3 Pr n 24b. Were au prior to death? 1 Yes	the cause of death? obably 4 Unknown topsy findings available completion of cause of
Vital Records, P.O.	Physician: The law requires that the death certif this certificate has been signed by the attending at director, page 2 should be detached for use a	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes	1 Live birth 2 (4 Pregnant at tin 9 Unknown ntributing to death but of the state of	pregnancy Fetal death 3 ne of death 5 not resulting in the u	Other (specify)	26. Place of Deal	1 Yes 24a. Was all autops perform 1 Yes 2 th (Check only only only only only only only only	Month pacco use contribute to as 2 \(\text{No} \) 3/Pr n 24b. Were au prior to cleath? 27-No 1 \(\text{Yes} \) and 3 \(\text{Prior} \) 1 \(\text{Yes} \) and 6 \(\text{Other} \) (Special contribute to cleath?	othe cause of death? obably 4 Unknown topsy findings available completion of cause of
of Vital Records, P.O.	ding Physician: The law requires that the death certif. h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 25 No 25. Was case referred to medical examiner? 1 Yes No 27. Manger of Death No 28. Was case referred to medical examiner?	1 Live birth 2 4 Pregnant at tin 9 Unknown	pregnancy Fetal death 3 ne of death 5 not resulting in the u 2 ER/Outpatier 28b. Time o	nderlying cause give	26. Place of Deal	1 Yes 24a. Was all autops perform 1 Yes 2 th (Check only only only only only only only only	Month pacco use contribute to as 2 \(\text{No} \) 3/Pr n 24b. Were au prior to content? 25-No 1 \(\text{Yes} \) 498	othe cause of death? obably 4 Unknown topsy findings available completion of cause of
of Vital Records, P.O.	Attanding Physician: The law requires that the death certificate has been signed by the attending rotor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 25 No 25 Was case referred to medical examiner? 1 Yes No 27 Manger of Death Natural Accident Accident 3 Suicide 6 Could not be	1 Live birth 2 (4 Pregnant at vin 9 Unknown htributing to death but of the second se	pregnancy Fetal death 3 ne of death 5 not resulting in the u 2 ER/Outpatier 28b. Time o Injury	nderlying cause give	26. Place of Deal	24a. Was an autops perform 1 Yes 2 th (Check only on ome 5 7 leside 28d. Describe ho	Month pacco use contribute to as 2 \(\text{No} \) 3 \(\text{Nore au prior to content?} \) 24b. Were au prior to codeath? 27b. No 1 \(\text{Yes} \) ance 6 \(\text{Other (Spectow injury occurred} \)	Day Year the cause of death? obably 4 □Unknown ttopsy findings available completion of cause of 2 No cify)
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of Vital Records, P.O.	lospital or Attanding Physician; The law requires that the death certif thours after death. timaral Diractor: After this certificate has been signed by the attending sly filled in by the funeral director, page 2 should be detached for use a	Certification: To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 25 No 9 Unknown Part II. Other significant conditions core Part II. Other significant core Part II. Other significant conditions	1 Live birth 2 4 Pregnant at tin 9 Unknown htributing to death but a respect to the second s	pregnancy Fetal death and resulting in the u Carlos Farm, str. Specify) pregnancy 3	nderlying cause give at 3 DOA Other f 28c Injury Work M 1 Y reet, factory, office	26. Place of Deal 7. 4 \(\text{Nursing Ho} \) at ? es 2 \(\text{No} \) e, date and place,	24a. Was an autops perform 1 Yes 2 th (Check only only only only only only only only	Month pacco use contribute to as 2 No 3 Property of the death? 24b. Were au prior to a death? 1 Yes ance 6 Other (Spectow injury occurred) reet and Number or Ru, State) ause(s) and manner as	Day Year the cause of death? obably 4 □Unknown topsy findings available completion of cause of 250 No cify) oral Route Number,
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Amend Item#19a per FH G849 11/16/05 CC Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#19a per FH G849 11/16/05 CC

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12**Physician** of obez Year SMAlls 13 2005 Ben Amin

4a. Facility Namb (If not institution, give street and number) 45 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Nursing Home Reisterstown <u>Baltimore</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days 87 Yrs. Director <u> 247-14-2200</u> SC Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 Church Road 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 SYes 2 No If Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black X□XWidowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade ges 1 and 2 should be filed vot Health and Mental Hygie if item 27 is marked other it na Minister Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Saul Smalls Irene Parker 19a. Informant's Name/Relationship (Type, Print) **Bartee** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Barter-Daughter 33 Church Road, Owings Mills, Md 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 10/18/05 Owings Mills, Md 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroic **Physician** leuchic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 **10**0 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 □ No Division of Vital 2 110 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 29b. Signature and title of confider 10 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 22a) (Type, Print) Main Street Suite 200 KEISTERSTOWN MD 21136 32. registrar's Signature 31. Date filed (Month, Day, Year) Carlo State 5 2005 Shipping Registra

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P.O. Box	wrequires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal	death 3	Ectopic pregnancy Other (specify)	′			1	Date of delive Month		Year
	s that i	by Ph	Part II. Other significant conditions co	ntnbuting to death bu	t not resu	Iting in the un	iderlying cause giv	en in Part I.		23e. Did tot	pacco use co	entribute to th	ne cause of d	death?
ords	law requires that the as been signed by th 2 should be detache									1 🗆 Ye	s 2 No	3 🗌 Prob	ably 4 X	Jnknown
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VII a	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?	14						neck only on				
0	<u>a</u> = <u>a</u>	. To	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury		ER/Outpatient		4 A I I I I I I			nce 6 🗆 O	ther (Specifi	1)	
	Attending I r death. ector: After by the funer	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Injur Wor M 1	k? Yes 2.⊟No	1	Describe no	w injury occ	unea		
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At hor (Specify)	me, farm, stre	eet, factory, office			Location (St. City or Town		nber or Rura	l Route Num	ber,
	Hospit 24 hours Funeral letely fille	edical C	29a. Certifier 1 ☐ Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner state	examinati	vledge, death ion and/or inv	occurred at the tir estigation, in my o	ne, date and pinion, death	place, and o	due to the ca t the time, da	tuse(s) and rate and place	manner as st e, and due to	ated. the cause(s	
	To th Withir To th comp	Me	29b. Signature and title of certifier				29c. Licens			2		ned (Month,		
			1-				104	372	-s		10/	19/05	5	
	10		30. Name and address of person who c				,							
	Sta	te	DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)		's Signati	Y VALI	EY RD.	TIMONI	UM, M	D 2109	93			
S. C.	Registr		OCT 2 5 2	32. Registrar	ار م	5 Ag	344							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36662 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Robert Russell Seibert, Jr. SI4S AM October 23 2005 /Medical 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 2, 19 Birthplace (State or Foreign Country) **Funeral** 212-48-7598 1**X**XM 2□ F 58 1946 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e 23a or 28a-f show t√yYes 2 No Director Maryland | N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 310 Ridgemeade Road 21210 USA Funeral r then "natural", or Iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo White Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Center Office Technician Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; if Item 27 is marked oth eny liquy or other traumatic event ONE. Robert Russell Seibert, Sr. Hazel Elaine Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Seibert Wife 310 Ridgemeade Road, Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/05 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio mimorory
Due to (or as a consequence of): 10 MIKUTES /Medical Examiner Houte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronera Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Loyess Diabetes Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sign 1 ☐ Yes 2 ☑ 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2/40 2 No 1 Yes 1 Tes : After this certifical funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident ector: 3 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 2438946

State Registrar

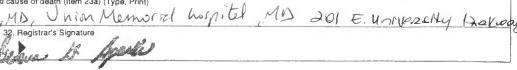
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5 2005

RAJA-ELIG ABDULNOUR

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			For State Registrer	State	of Maryland		rtment of F tificate of		l Mental Hyg	iene 9. No. 0 0 5	34443
Ì	Physici /Medic		Decedent's Name (First, Middle James W.	, _{Last)} Stevenso	on				2. Date of Deat Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution Union Memori	give street and no	ımber)		4b. City, Town, o	r Location of De Ltimore		4c. County of Deat	h
	Funeral		5. Social Security Number 175–14–0912	6. Sex 1 /CX M 2□ F	7. Age (In yrs. Ia.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	n. (Month, Day,	Year) 9. Birti	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	nation		Aug. 21	, 1919 Per	Insylvania
	a-f shov	ctor	Maryland N/A	A		1timor					1 X Yes 2 □ No
	with the	I Dire	10e. Street and Number 2211 W. Rogers	Avenue	6		10f. Zip Code 212	<u>09</u>	1	0g. Citizen of What Co USA	untry?
	er death	Funeral Directo	11. Marital Status	12. Was Dec Armed F		. 13. V			(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
3036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Itams 23e or 28e-1 show imatic avent, the Medical Examiner must be notilled at	by	1 Never Married 2 X Marr	ed 1 XYes If Yes, G Year or I	2 □ No ive WWII Dates: WWII	1	☐Yes 2☐No	Specify:		Specify: Wh	ite
Maryland 21215-0036	hould be filed within 72 h d Mental Hygiene. narked other than "natu natic avant, it e Modical	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of w d)	vorking	16b. Kind of Business/	
d 21	filed wit Hygiene other tha		12 17. Father's Name (First, Middle,			Ger	neral Car		n lame (First, Middle, I	Railroad	
ylan	should be nd Mental marked o	To Be	James William		n			Alice			
	and 2 and 2 and 2 and 2 rest		19a. Informant's Name/Relations Doris Stevenson			19b. Mailin 2211	g Address (Street . W. Roge	ers Aven	Rural Route Number ue Baltin	; City or Town, State, 2 nore, Maryl	tip Code) and 21209
altimore,	Pages 1 are nent of Hea Int: If itam Inty or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Chate	metery, cren	sition <i>(Name of</i> natory or other plac Park Cem			20c. Location - City or $Nood1$ awn, M	
Baltir	permit. Pages Department of I Important: If its any injury or o		21. Signature of Tuneral Service							Home, Inc. Maryland	
	00 F 8 0		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death.	Do not ente	031 Falls are the mode of dying	Road,	Baltimore, iac or respiratory arre	, Marýland est,	Approximate Interval Between
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	tendo	cell	4/9	- C	non		Onset and Death
	Examiner		Sequentially list conditions.	b	o (or as a conseque						
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conseque	ence of):					
8760,	cate be executed physician and the buriat-transit	al Exa	resulting in death) Last	Due to	(or as a conseque	ence of):					
Ö	artificate ing phys e as the	Medical	IF FEMALE:	d							
. Box	The law requires that the death certific tie has been signed by the atlending p bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live 4□Preg	utcome of pregnand birth 2 Fetal o mant at time of dea	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	very Day Year
P.0	es that the de igned by the a be detached f		9 Unknown Part II. Other significant condition	9 Unk		ting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Records,	w requires been sign should be	ted by							1 □ Y€	es 3 No 3 Pro	obably 4 Unknown
	The law are has b	Completed							24a. Was a autops perform	y prior to death?	topsy findings available completion of cause of
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			25 DOA Ott	or	eath (Check only on		22 No
	tending Physeath. tor: After this the funeral di	on: To	27. Manner of Death	28a. Dat		R/Outpatien 28b. Time of Injury	3 DOA	4 ∐ Nursing y at	Home 5 Reside	ence 6 Other (Spec ow injury occurred	ify)
Division of	ten leat tor: the	Certification;	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	e of Injury - At hon			Yes 2 □No		reet and Number or Ru	ral Route Number,
ā	는 는 는 는				ding, etc. (Specity)		a popular the time	no dete and sla	City or Town	ause(s) and manner as	
)	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	(Check only 2 Medical one)	Exeminer: On the	basis of examination	on and/or inv	estigation, in my o	pinion, death oc	curred at the time, da	ate and place, and due	to the cause(s)
}	To Toon	×	29b. Signature and title of certification	m-8			29c. Licens	e number	2:	9d. Date signed (Month	n, Day, Year)
	6X1		30. Name and address of person	who completed car	use of death (Item 2	23a) (Type,	Print)	٦ ١	Dect A-	1	72120
* 14	Sta		31. Date filed (Month, Day, Year)		Registrar's Signatu	Ire	and I	-1100	U'CEI NJ	11,40 10 1	NAIN
	Regist	rair	nct 2	5 2005	GARLES A	To play	200				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene O O E

			1 - For State Registrar		State of Ma	iryiand /		ment of i ficate of		mental H	lygien Reg. N	とししつ	34444
	Physici /Medic		Decedent's Name (First		LES S	EIBE	EKT			2. Date of Month	Death 12	ay Yea	3. Time of Death
)	Examir		4a. Facility Name (If not in					b. City, Town, o	or Location of Dea			o. County of De	
	Funeral		5. Social Security Number		7. Age	(In yrs. last t		f Under 1 Year fonths Days	If Under 24 Hr. Hours Min	S. 8. Dale of I	Birth Day, Year	9.8	inthplace (State or Foreign Country)
	Director		Usual Residence of Dece			07				ØCJ, [3	3)19	7/1	Jub.
	deeth with the Maryland ms 23a or 28e-f ehow criust be notified at	ţō	10a. State 10b.	County		10c. City, To	wn or Local	on ON F					10d. Inside City Limits 1 Fres 2 No
	vith the	Director	10e. Street and Number	7-1	. 1	PA	1 1 1	10f. Zip Code				itizen of What (-
	deeth v rms 23g	Funeral	11. Marital Status	ELAIR	12. Was Decedent E	ver in U.S.	13. Wa		1206 Hispanic Origin? (: an, Mexican, Pue	Specify Yes or			nerican Indian,
2-0036	172 hours after deeth with the Marylan "naturel", or Items 23a or 28e-1 ehow adical Exartiriar must be notified at	ρ	1 ☑ Never Married 2 3 □ Widowed 4 □ D		Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0		es, specify Cub	_	rto Hican, etc.)		Black, Wh	onite, etc.
2-0	within 72 ho ane. then "natur	leted	(Specify on	Decedent's Edu ly highest grad		16	a. Deceden (Give kin	I's Usual Occup d of work done	pation during most of wo	orking	16b. I	Cind of Busines	s/Industry
717	ed withi	Completed	Elementary/Secondary	2	College (1-4or 5-	+)		NKNO				ONKA	الاشامة
and	d be fill	To Be	17. Father's Name (First,	Middle, Last)	UNKA	201011)		18. Mother's Na		lle, Maide 10 W)		
lary	2 should and Mile mari	-	19a. Informant's Name/R	elationship (T	ype, Print) DARL	ENE 19		Address (Street	and Number or R	Tural Route Num	nber, City	or Town, State,	, Zip Code)
ē,	s 1 and Health tem 27 other tr		20a. Method of Dispositio	2 AGI	No	20b. Place	OD. of Disposition	On (Name of	RT ST =	#300 Date	BAL 200. L	JO, MI.	2/202 or Town, State
	nit. Pages 1 an artment of Heal ortant: If item 2 injury or other it.		1 ☐ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	ther (Specify)	ENTOBMER	DRL	ery, cremate	ory or other pla	EM 20	T. 21 205	BA	LTIMON	CE, KD.
ng Pa	Departiment Departiment Departiment Departiment Departiment Department Depart		21. Signature of Funeral	Service Licens	Skarke	Z.Jr.	22. N	ame and Addre	SS of Facility	829 H	UDS	10.21	- 1 22il
			23a. Part1. Enter the dis- shock, or heart failu Immediate Cause (Final	ease, o comp re. List only o	lications that caused the cause on each lip	the death. Do	not enler t	0 -					Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-	a. Due to (or as a	consequence	<u>かい</u> e of):	e pi	neum	omia			
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/	acuted ind transit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	. De	eme	ent.	a					
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	certificate ding physise as the	-	tF FEMALE:		23c. If was outcome o	d orogonom.							
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7 10	Physici this cer al direct	To B	examiner?	-	Hospital: 1 ☐ tnpatier			3□ DOA Oth	er: 4 Nursing I	Home 5 Re		6 □Other (Sp	ecify)
<u>Б</u>	Attending Physicien: r deeth. ector: After this certific by the funeral director.	atlon;	27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	28a. Date of Injun (Month, Day	Year) 28b.	Time of tnjury	28c. tnjur Wor M 1 🗆	yat k? Yes 2 ⊡No	28d. Describe	e how inju	ry occurred	
DIVIS.	To the Hospital or Attendi within 24 hours efter deeth. To the Funerel Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Ptace of tnju building, etc.	ry - At home, f (Specify)	arm, street,	factory, office		28f. Location City or T	(Street allown, State	nd Number or F 9)	Rural Route Number,
	To the Hospital or within 24 hours efta To the Funeral Dir. completely filled in I	Medical C	29a. Certifier (Check only one)	ertifying Phy fedical Exami	sician: To the best of	examination a	ge, death oc nd/or invest	curred at the tir gation, in my o	ne, date and place pinion, death occ	e, and due to thurred at the time	e cause(s) and manner a d place, and du	as stated.
	To the within ? To the comple	Mec	29b. Signature and the of		and manner stat	ea.		29c. Licens	e number		29d. Da	te signed (Mon	nth, Day, Year)
,			> ICCLE	w	M)	- Ab (11 22)	<i>T</i>	D	253	91	1	0-29	1-2005
	1		30. Name and address of	HV.	5601-	LACI	L Pric	zven	Blva	1 13	all	4008	L-2005 E N921239
	Sta Registr		31. Date filed (Month, Da)	y. Year) 2 .5 200	32 Registra	's Signature	Specie	e e					

			1 - For State Registrar	State of Mar		artment of H		Re	eg. No.	34445
ı	Physici	an	1. Decedent's Name (First, Middle, Last) Jeanne Fr			Charr		Date of Deat Month	th Day Year	3. Time of Death
	/Media			ances		Shay		10-24-2		2:45 A ^M
	Examin	er	4a. Facility Name (If not institution, give s Genesis Elder Car				Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	Brookly If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne Aru	
п	Funeral Director			M 20XF	79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2-28-19	Year) Co	thplace (State or Foreign ountry)
	P.		Usual Residence of Decedent							
	arylar show	<u>.</u>	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	he M.	Director	MD Anne Arun 10e. Street and Number	del	Glen Bu					1 Yes 2 No
	with t			-1- D1 #/	.02	10f. Zip Code			0g. Citizen of What Co	ountry?
	Jeath ns 23	Funeral	7466 Furnace Bran	12. Was Decedent Ev		21060 Was Decedent of Hi	spanic Origin? (Spe		U.S.A.	erican Indian.
ထ	after or iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🖄 No	,	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
93	ours a	d by	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:		Specify: Wh	itte
5-0	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show ta M.olcal Exa. itrer mat be netitled at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occupa	during most of worki	ing	16b. Kind of Business	/Industry
121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+))	DO NOT use retired			AA County	Police
d 2	filled Hygie of ther		17. Father's Name (First, Middle, Last)		CFC	ossing Gua	18. Mother's Name		AA County	rolice
an	ld be ental ked o	To Be	William A. Chapli	n			Agnes I.			
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "naturat", or items 23a or 28a-f show other traumatic event. If a Madical Exa., it ar mark by neitilized at	-	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street a			, City or Town, State,	Zip Code)
Σ	and 2 alth a 127 is	1	Gerry A. Shay / Son		112	First Ave	e W Glen H	Burnie,	MD 21061	
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	θ)	Date	20c. Location - City or	Town, State
Ĕ	Pages ment of I ant: If its		' 4 ☐ Donation 5 ☐ Other (Specify)						Glen Burni	
3all	permit. Pages Department of Important: If ii any injury or o		21. Signat of Tera Service Cense						Funeral Ho	
	40 = 80		28a. Part1. Enter the disease, or compli	M01120					Le, MD 2106	Approximate
	/Medical Examiner	miner	slock, or heart failure. List only on lamediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Qause (Disease or injury	Due to (or as a		SE CEL	L NONH	608K/1	rs Lympho	Interval Between Onset and Death
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	an/Medical Examin	23b. was decedent pregnant	Due to (or as a l 3c. If yes, outcome of 1 □ Live birth 2		Dectopic pregnancy			23d. Date of de	•
P.O. B	of the deal by the att tached fo	Physician/M	in the past 12 menths? 1 ☐ Yes 2 X No 9 ☐ Unknown	4 Pregnant at ti		Other (specify)			Month	Day Year
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ita	iclan: T	Be C	25. Was case referred to medical examiner?				26. Place of Death		~	
کر د	Physician: this certific ral director,	5	1 ☐ Yes 2 ▼No	lospital: 1 Inpatient			4 Mursing Ho	me 5 Reside	ence 6 Other (Spe	icify)
Division o	ing After unei	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work	yat k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divi	i Ditte	Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or R n. State)	ural Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	ledical	(Check only 2 Medical Examination)	ner: On the basis of e and manner state	examination and/or in ed.	vestigation, in my or	oinion, death occurr	ed at the time, da	ause(s) and manner as ate and place, and due	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	2:	9d. Date signed (Mont	h, Day, Year)
,			V	am/ms		D (1 130		10.24	. 2005
	le		30. Name and address of person who co	mpleted cause of dea	23a) (Type)	Print) Hurcut	ST BA	LIMO	9d. Date signed (Moni 10 · 24 NE, WD 2	1225 .
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 5 2005	Hegistrar	s Signature	Sel.				

State of Maryland / Department of Health and Mental Hygiere 05 34446 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** James Edward Smithson October 20. 2005 10:27 Å /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2629 Long Meadow Drive Abingdon Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ⊋M 2 ☐ F 53 Director 153-44-6505 10, 1952 Pennsylvania Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Itams 23a or 28a-f show Examiner must be netified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2629 Long Meadow Drive 21009 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) District Manager Linen Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental out: If item 27 Is marked o John Wynne Smithson Marie (UNK) McGintv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gay Joyce Smithson/Wife 2629 Long Meadow Drive, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Importent: If any Injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery | 10-24-05 Darlington, MD 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 21. Signature of Funeral Service License 23a. Part. Enauthe disease, or complications that caused be death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 □Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3ET DOA Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) HOLABIRD AVE BALTO, Md 21222 State 2005 Registrar

State of Maryland / Department of Health and Mental Hygieme o o c

					Otate of W	arylari	Cer	tifica	te of L	Death	Wichtai 11	Reg. No.	15 3	444/
			1. Decedent's Neme (First	t, Middle, La:	st)			-			2. Dete of D	eath		3. Time of Death
	Physicia /Medic		IF	215	SCHE	ERR	2				OC T	1947	Year Zoos	1-15 PM
	Examin		4e Fecility Name (If not in	nstitution, giv	e street end number)				4	b. City, Town, o	Location of Dea			
			Brightwoo	d Nurs	ing Center	c				Lutherv	ille	Ва	ltimore	
	Funeral		5. Social Security Number	r 6. S	Sex 7. Ag		last birthday)	If Und	er 1 Year Days	If Under 24 Hr Hours Mir		rth ay, Year)	9. Birthplac	e (State or Foreign
	Director		215-42-6770		□M 2√7 F	62	Yrs.				Apr 11	, 1943	Maryla	
	pur s		Usual Residence of Dece 10a. State 10b.	County		10c. City	, Town or Loc	ation					10d.	Inside City Limits
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	ath with the Marylar 23e or 28e-f show	₫	6655 Sanzo	Road						1209			USA	
	leath 22	era	11. Marital Status		12. Was Decedent		S. 13. W	/as Dec			Specify Yes or N rto Rican, etc.)	o- 14. Ra	ce - American	
21215-0020	permit. Pages 1 and 2 should be filiad within 72 hours efter death with the Maryland Department of Health and Mantel Hyglana. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 3 □ Widowed 4 □ D		Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give △ Year or Detes:	No			ecity Cuba	n, Mexican, Pue Specify:	rto Hican, etc.)		ck, White, etc. ^{'y:} White	
50	72 ho	g	15. C	Decedent's Ed	ducetion ade completed)		16a. Decede	ent's Us	ual Occupa	ation	orkina	16b. Kind of B	usiness/Indus	try
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Baltimore,	Pages tment of tent: If it		1 ☐ Buriel 2 ☐ Cre 4 ☑ Donation 5 ☐ 0	metion 3 Other (Specify	y)		emetery, crem	atory or	other plac					
Bal	permit Depar Impor any in		21. Signature of Funerati	ld S.	Wade Dir	ector	St	ate	Anato	ss of Fecility Omy Boar MD 212	d 655 W	. Baltim	ore St	reet
	T T		23a. Part1. Enter the dis shock, otheart failu	ease, or com-	plications that cause one cause on each li	d the death	. Do not ente	r the m	ode of dyin	g, such as cardia	ac or respiratory	arrest,	Int	proximate terval Between
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Box	ath o	lan												
P.O.	the ched	ysle	Part II. Other significant	conditions o	ontributing to death b	ut not resu	ulting in the un	derlying	cause give	en in Part I.				e cause of death?
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on of	ding Phy h. After this funerel		27. Manner of Death Netural 5	Pending investigation	28e. Date of Inju (Month, De	iry y Year)	28b. Time of Injury	М	28c. Injun Work			how injury occur		
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	Sta Registra		31. Date filed (Month, Da	y, Year)	32 Registr	ar's Signa	ture	منا						

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_			1 - For State Registrar	State of Mary	land / Depa	artment of H	lealth and N		giene () 5	34448
	Physic /Med		Decedent's Name (First, Middle, Last) IRVING		S	CHREIBER	G	2. Date of De Month OCTOBE	ath Day	Yeer	3. Time of Death 3:07 P M
	Exami		4a. Fecility Name (If not institution, give st HEBREW HOME OF GRE 5. Social Security Number 6. Sex	ATER WASHI		4b. City, Town, o			4c. County		
	Funeral Director		213-34-1559 Usuel Residence of Decedent	M 200 F	yrs. last birthday) No. 1	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De 08/18/1	y, _{Year)} 937	9. Birthi Coul	place (State or Foreign ntry) MD
	urs after deeth with the Marylar el', or items 23a or 28a-f ehow Exammer must be notified at	Director	MD MONTGOMEF 10e. Street and Number		ROCKVILL					1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eeth with 18 23e or must be r	Funerai Dir	6121 MONTROSE ROA			10f. Zip Code 20852			10g. Citizen of V	Vhat Cour	ntry?
0036	"naturel", or iten	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I□ Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blace Specify	k, White,	can Indian, etc. IITE
21215-0036		Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Deced (Give life. 1		ation during most of worki)	ng	16b. Kind of Bu		,
Maryland	e da de y	To Be	17. Father's Name (First, Middle, Last) ELLIS 19a. Informant's Name/Relationship (Type	Print)	SCHREI		18. Mother's Name		Maiden Sumam	e) ROSEN	STEIN
	of Health of Health I item 27		LOUIS SCHREIBERG / 20a. Method of Disposition 1 Substitute 2 Cremation 3 Rer	BROTHER	7 H		COURT - (WINGS M		D 21	117
Baltimore,	permit. Page Department Important: If eny injury o		4 □ Donation 5 □ Other (Specity) 21. Signature of Funeral Service Vicenses	noval frogi State		CIRCLE Name and Addres			BALTIMOR SON & BR		
68760, 1	Physician physician and Medical Examiner It is possible to the properties of the project of the	edical Examiner	2.a. Part1. Enter the disease, or comilica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Mycas	sequence of):	or the mode, of dying	ERSTOWN R	CUAU - P	PIKESVII.	1	MD 21208 Approximate Interval Between Onset and Death MANUAL ACAL ACAL ACAL ACAL ACAL ACAL ACAL A
P.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as:	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etel death 3 DE	Ectopic pregnancy Other (specify)			23d. Date Mont		y Day Year
Records, F	w requires that the sbeen signed by the should be detach	sted by P	Pan II. Other significant conditions contrib	outing to death but not	resulting in the und	derlying cause giver	n in Part I.				cause of death?
Vital Rec			HAM SAM 25 Was case referred to medical	M			26. Place of Death (pri 1ed? de No 1	or to com ath? Yes 2	sy findings available pletion of cause of
of	fing Ph n. After th funeral	၉	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	oital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Yeer,		3 DOA Other 28c. Injury a Work? M 1 Ye	Nursing Home 28 28 2 No	e 5 Resider	nce 6 Other w injury occurred	1	
D	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifying Physici	Building, etc. (Spe	rnowladge, doesh c			City or Fown,			
)	To the H within 24 To the F complete		29b. Signature and title of certified	and manner stated.		29c. License r	number	at the time, da	te and place, and d. Date signed ($\frac{1}{20}$	d due to th	he cause(s)
	Star Registra	e	ALL OTCLY L KIGHT	eted cause of death (It	ZIMIN	Mose Ko	Likock	ulle,	UD 2	USS	,2
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ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 34449 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOSEPA SCHAPS E 7:43 PM 0040615 19 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Howard County General Hospital Şex 130 M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Director 472-12-2586 March 10, 1923 Minnesota Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 5320 Dorsey Hall Dr. Apt 314 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 Decedent Ever in U.S. Amed Forces?
1 Decedent Ever in U.S. Amed Forces?
1 Decedent Ever in U.S. Amed Forces?
1 Decedent Ever in U.S. Amed Forces in U.S. Amed For Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Computers / Jewlery Making Elementary/Secondary (0-12) College (1-4or 5+) Computer Tech. / Watchmaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Fabeck Peter Joseph Schaps ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4136 Henhawk Ct. Ellicott City, Maryland 21042 Mrs. Therese Deane Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10/21/2005 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) **Bayview Crematory** ature of Funeral Sance Libensee 22. Name and Address of Facility MO1293 Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease shock, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician a Light Chair moltiple myeloma 4 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Rinal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown to myeloma 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed re effer death.
If all Director. After this ceruinated by the funeral director, pe 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 7 2 ER/Outpatient 3 DOA 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 0 30573 MD 10-20-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n 11065 Little Patoxing Parking Colombia MD 21044 Jon Winford. MO 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar 2005

,		1 - For State Registra Americ	d Ite	n #10a Pe		nd / Depa 348_107						Reg. No	UUJ	34450	
Physic	ian	Decedent's Name (F	irst, Middle,	, Last)							Date of De Month	Da		3. Time of Death	
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LAGIIII				6440 Rock	Glen Drive					Elk	ridge			loward	
Funeral		5. Social Security Numl	ber	6. Sex 1 ☐ M 2 ☐ F		s. last birthday)	If Unde Months	r 1 Year Days	If Unde Hours	r 24 Hrs.	8. Date of Bi (Month, Da	rth ay, Year)	9. Bir	thplace (State or Foreign ountry)	
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nyland how		10a. State 10 Maryland	0b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits	
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or ite	by Funeral	1 Never Married	_	Armed F ed 1 Tes If Yes, G	2 X No		f Yes, spe	ecify Cuban	n, Mexica	an, Puerto	Rican, etc.)		Black, Whi		
filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. Thygiene. Inter than "nature!", or items 23a or 28e-1 show out, the Medical Examinar must be notified at		3 Widowed 4		Year or I	Dates:		1□Yes		Specify				Specify:	White	
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od 2 sl lith and 27 is r		19a. Informant's Name			0						i Roule Numb e, Marylan		or Town, State, . 75	Zip Code)	
is 1 ar of Hea other		Mr. William 20a. Method of Dispos	ition			Place of Dispo	sition (Na	me of	1		ate	-	ocation - City or	Town, State	_
Page nent c		1 □ Burial 2 🔾 0 4 □ Donation 5 [State	-	•	ematory		10/2	1/2005		Baltime	ore, MD	
perillicity, Indi yidilicity 15.15.15.05.00 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinational be notified at any pince.		21. Signature of Furier	11	idense			. Name a	nd Address	s of Faci	•					Ī
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Attending ar death.	catl	2 Accident	investig	ation			М	1 🗆 Y	'es 2[
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To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier ff	Certifying	g Physician: To th	e best of my kr	nowledge, death	h occurred	at the time	e, date a	ind place, a	and due to the	cause(s) and manner a	s stated.	-
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State of Maryland / Department of Health and Mental Hygiers For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Scott Eric Trahan Month **Physician** 10 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Balhmore Medical Center MD University of Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 □ F 219 88 5259 28 1972 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or itama 23a or 28a-f shov other traumatic event, the Modical Examinan must be fulfilled at 1 Yes 2 No CARROLL SYKESVILLE mo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? USA BRIDOON AVENUE 217-8 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: White If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) OUR OWN, IN Elementary/Secondary (0-12) College (1-4or 5+) at Hygiene. VOLUNTEER MANAGER 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and Mental LINDA M. HURST 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i SYKESVILLE MO 21784 FAUL A. TRAHAN / FATHER 7115 BRIDDON AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of F importent: if ite any injury or ot. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GRAINE PARK CEM 10/25/2005 Ubustawn, mo 22. Name and Address of Facility JN ZUMBRWN FH & mon Co 21. Signature of Funeral Service Licensee umbrun 23a. Part Lever the disease of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6028 SYKESVILLE RUAD ELDEAS BURG-MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GEPSIS Physician /Medical Due to (or as a consequence of) Examiner Preimonia Aspirahm Sequentially list conditions, if any, leading to immediate cause. Litter to derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physicien the detached for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the great vessels Transposihm 2 No 1 🗌 Yes 3 Probably 4 Unknown hypoalbuminema 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificate has b lirector, page 2 si 24a Was an autopsy 1 Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 ZNatural 5 Pending death. 1 ☐ Yes 2 ☐ No hours after death uneral Diractor: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M' Clam Gerena Lynn 10/21/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, DC 20020

DHMH 17 Rev 1/2001

State Registrar

Serena McClam

31. Date filed (Month, Day, Year)

9 St SE

32. Registrar's Signature

1302

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item//19a, perFh, C848, 10-28-05 TT
State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** oCTOBER Day 21 2005 LULA Μ. THOMAS 6:23AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours | Min. | 10 / 08 / 1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2**%**] F 220-36-6983 67 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 N. GRANTLEY STREET 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No ģ Specify: BLACK Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE'S AIDE MEDICAL 12 TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES PAIGE FANNIE YERBY ဂ 19a. Informant's Name/Relationship (Type, Print)

Relin

Christopher Belvin / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 3613 HAYWARD AVE., BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/27/05 KING MEM. PARK 4 □Donation 5 □Other (Specify) RANDALLSTOWN, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Areral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) LUNG CANCER Months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 poinths?

1 Yes 2 1 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify OS) 1 ☐ Yes 2 No Certification: To 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician:

Funeral

Director

28a-f show

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items 23a

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Important: If it
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Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

I Director: A d in by the fu filled in by within 24 hours after To the Funerel Dire ro the

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State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier

29c. License number D58303

29d. Date signed (Month, Day, Year) OCTOBER 21 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AARON Charles, up 6601

Charles St Torrson ms 21204

31. Date filed (Month, Day, Year)

29a. Certifier

Medical

32. Registrar's Signature

OCT 2 5 2005 Elemenes GREGORY TURNER 05-0**71**85

07.	10)		1 = For Unpend Item 2	State of Maryla 3a,27,28a-f	nd/Depar per me G	tment of I 849 11- ficate of	lealth and 15-05 ta Death	Mental Hy s	giene 0 0	5	34453
5.5	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi	cal	GREGORY TURNE						r 24, 200	05	5:48 a.™
-	Exami	ner	4a. Facility Name (If not institution, give 4829 Wilern Avenue	street and number)		b. City, Town, o Baltin	or Location of Dea	ath	4c. County		/A
	Funeral Director			7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hi Hours Min	8. Date of B (Month, D 12/2	irth 2 <i>y, Year)</i> 2/1958	9. Birthp	place (State or Foreign htry) ARYLAND
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	the Marylar 28e-f show	ctor	MD N/A		BALT	IMORE	СІТҮ			ŀ	Y☐Yes 2☐No
	or 28	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Cour	ntry?
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	illed Hygid other	0	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	e, Maiden Sumami		
/lar	Mental Mental arked c	To B	BRYANT D. D.	IXON			ROSA	M. TUR	NER		
Maryland	2 sho and is ma reumer		19a. Informant's Name/Relationship (Ty						ber, City or Town,		
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mor	Pages ent of ht: If it		XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crema	tory or other pla	_{се)} ERY 10/		BALTT		CO., MD
Baltimore,	permit. Pages Department of important: If if any injury or one.		21. Signature of Smeral Service License	** X. X	22.1	ame and Addre	ess of Facility H	OWELL 1	FUNERAL	HOM	IE 21207
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_	To the Hospitel or Attant within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exemination	Scene sicien: To the best of my kneer: On the basis of examination	nowledge, death o	ccurred at the tir	me, date and place	Dalling	ore, ma	nnor as et	ated
	ithin 2 o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed		
	F \$ F 0		· Pamil Bowthe	W. MD		OC			October 0	24,	2005
			Hamelle. 2011	mpleted cause of death (Ite		int) 111 Po	enn Stre	et Balt	imore, M	ary1a	and 21201
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Amend item 24a 27 per doc 9848 10-25-05 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SUSIE TOWNSEND OCTOBER 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE THWEST ANDALLSTOWN If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 F 8 Director 07-12-27 Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumetic event, the Medical Examiner must be notified at 1 Yes 2 □ No MD. Director TIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code WINDSOR UISIA or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status nit. Pages 1 and 2 should be filed within 72 hours after arment of Health and Mental Hygiene. Total crient: If item 27 is marked other than "natural; or lies injury or other traumetic event, Its Medical Examina 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: Š Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WING Willie 19a. Informant' Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #101 hALTO.MD. MT. BATTEN COURT LOWNSEND 21207 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or MT. CARMEL CEMETON 10-22-05 BATTIMORE, MD. □Donation 5 □Other (Specify) 22. Name and Address of Fability PHILLIPA. Weatherford Funeral Services 21. Signature of Funeral Service Licenspe 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO, MD. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of a HYPERIENSION burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 2 **(1)** MG 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 Tyes 2 🗆 No 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours a To the Funerel E To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person

DR. LAURIA

J HAPLAN

5

OLD CT

who completed cause of death (Item 23a) (Type, Print)

5401

32. Rastrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie 0 5

			For State Registrar		Department of Health and Certificate of Death	Reg.	No.	
	Physici	an	1. Decedent's Name (First, Middle, La				Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	ath OCTOCER	4c. County of Death	3.70
	Funeral Director		5. Social Security Number 6. S	Con motion	thday) If Under 1 Year If Under 24 Hr Yrs. Days Hours Mir		BATIMO 9. Birtho Cour	lace (State or Foreig
	p.		Usual Residence of Decedent	10a City Taw				
	laryla shov	5	10a. State 10b. County	10c. City, Tow	n or Location		1	0d. Inside City Limits 1 ☐ Yes 2 No.
	the A	rect	10e. Street and Number	2015 LUI	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	h with	i i	9130 AvanOA)	5 ROAD 7	21234		12.S.A.	
25	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show item 27 is marked other than "natural; or items Ea routified at other traumatic evant, the Medical Examt at must be routified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Americ Black, White, Specify:	
5	72 hou	ted	15. Decedent's E (Specify only highest gr	ducation 16a	Decedent's Usual Occupation	16b	. Kind of Business/In	dustry
V	filed within 72 Hygiene. Other than "nai ant, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of will be DO NOT use retired) RODFREADER		ST. SMIT	01 H
	d be findal Had ad ott	Be.	17. Father's Name (First, Middle, Last		18. Mothers Na	ame (First, Middle, Maio	den Sumame)	
ınaı yıarıd	2 should be and Mental I is markad o	င္	19a. Informant's Name/Relationship	Type, Print) 196	Mailing Address (Street and Number or F	Rural Route Number, Cit	ty or Town, State, Zjp	Code?
	1 and 2: Health au tem 27 is		Charles F. E	vans Jr. 1.5	evans chapel of	memories	8800 Ho	irrora ka
Dalilli Ole,	0 0		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □	cemete	t Disposition (Name of ry, crematory or other place)		Location - City or To	own, State
	nit. Pages artment of l ortant: if it injury or o	1	`4 □ Donation 5 □ Other (Speci	di Worls	TOUR PULLER S	Acos TE	VXXXXXX	'lardland
3	permit. Pag Department Important: i any injury o once.		21. Son Ure of Funeral Pe Lice	1		OAD HARKYI	ns work	to aust
J	Enysician		Immediate Cause (Final	one cause on each line.	not enter the mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or s a consequence	of):			
	physician and burial-transit au	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence		lisease		
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25⊠ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
6	es that i igned by be deta	by Ph	Part II. Other significant conditions	contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
מכסומא,	w require been sig should b	ted				1 🗌 Yes	2≸ No 3 Prob	ably 4 Unknow
	: The law a cate has but page 2 st	Completed				24a. Was an autopsy performed	prior to condeath?	psy findings availabl mpletion of cause of 2 No
<u> </u>	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Other	eath (Check only one) Home 5 Residence	0 DOther (0	
	Jing After fune	ation; To	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Time of njury M 1 Yes 2 No	28d. Describe how in		//
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not to determined		arm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	he Hospi: n 24 hour he Funeri	Medical (29a. Certifier (Check only one) Certifying P	hysicien: To the best of my knowledge miner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
	To the To the Comp	Σ	29b. Signature and tille of certifier		29c. License number		Date signed (Month,	Day, Year)
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Λ.			- 1. m	completed cause of death (Item 23a)	(Type, Print) Ophwood Road	Cla D.	coia a N	2.54
11			JUDE MINNESS	THAL CAN T		1 - 10 - 10		

			1 - For State Registrar	ate of Maryland /	Department Certificate	of Health and of Death		giene Reg. No.	34456
34	Physici /Medio		Decedent's Name (First, Middle, Last) WILBUR GRANT	' VALENTINE			2. Date of De. Month	Day Ye.	
	Examir Funeral Director		4a. Facility Name (If not institution, give street 5. Social Security Number 6. Sex 213-28-9255	HOS OITAL 7. Age (In yrs. last bi	ROS		8. Date of Bin	y, Year)	
	Maryland -f show lied at	tor	Usual Residence of Decedent		wn or Location	ITY			10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23s or 28s	al Director	10e. Street and Number 2404 MONTEBELLO	TERRACE	10f. Zip C	^{Code} 21214		10g. Citizen of What	Country?
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23s or 28s-1 show event, i're Medical Exertirer must be notified at	by Funeral	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces? ☑X es 2 □ No Yes, Give ear or Dates:		nt of Hispanic Origin? (S y Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. BLACK
21215-0036	filed within 72 ha Hygiene. Ither than "naturant, Ine Medical	Completed		ollege (1-4or 5+)	a. Decedent's Usual (Give kind of work life. DO NOT use SCHOOL PI	done during most of wo retired)		16b. Kind of Busine BALTIMOR PUBLIC S	
Maryland 21	should be filed nd Mental Hygid marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) LAWRENCE VALENTI			PHENOI	LA SIN	Maiden Sumame) GLETON	
	s 1 and 2 should f Health and Men itam 27 is marke other traumatic		19a. Informant's Name/Relationship (<i>Type, P</i> C. GRANT VALENTIN	IE / SON 2	2404 MONT	rebello ti	ERRACE,	BALTIMO	
Baltimore,	permit. Pages 1 Department of H Important: If ital any injury or ott		20a. Method of Disposition 1 Surial 2 Cremation 3 Remov 4 Donation 5 Other (Specify) 21. Signature The ral Service Licensee	val from State MD V		CEM . REST 10 /	WELL F	UNERAL H	ILLS, MD OME 21207
	Physician /Medical		23a. Part / Eprey the disease, or complication stock, or neart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	C V A	not enter the mode				Approximate Interval Between Onset and Death
68/60,	Examiner	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	melli	45			
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □Pregnant at time of death □Unknown	th 3 DEctopic prec			23d. Date of Month	delivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contribut	ing to death but not resulting i	in the underlying cau	se given in Part I.		/	o to the cause of death? Probably 4 □Unknown
Vital Records,		Completed	acute Renal	Failure			24a. Was autop perfor	sy prior	
	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	al:		04	th Check only o		
lon of	ling Phy	atlon: To	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	a. Date of Injury 28b.		4 Nursing F Injury at Work? 1 Yes 2 No		lence 6 Other (S	рөсіfу)
UIVISION		Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At home, fa building, etc. (Specify)	farm, street, factory, o	office	28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examiner: Cone)	To the best of my knowledge on the basis of examination are and manner stated.	nd/or investigation, in	n my opinion, death occu	rred at the time, o	date and place, and d	due to the cause(s)
١	To To	-	29b. Signature and title of certifier Wassin El		D	icense number 90 6 1 2 5 1		19(22 0	onia, Day, Year)
- 100 100 100 100 100 100 100 100 100 100	/ D Sta Registr		30. Name and address of person who completed the person who can be personally and person who can be personally as a person who can be personally as a person who can be personally as a person who can be personally as a person who can be personally as a person who can be personally as a person who can be personally as a person who can be personally as a person who can be person who can be person who can be personally as a person who can be personally as a person who can be personally as a person who can be person who can be personally as a person who can be personally as a person who can be personally as a person who can be personally as a person who can be personally as a person who can be person who can be personally as a person who can be personally as a person who can be person who can be personally as a person who can be person	Hitti 9000:		Squale Dri	ve Balt	limore, M	D 21237

State of Maryland / Department of Health and Mental Hygien 0.0534457 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Mary Edna Vaught 10 20 2005 <u>07:23</u>🏻 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖸 F 87 216-30-6816 Yrs Director 10-03-1918 North Carolina Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits in then "netural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at MD Director Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12325 New Hampshire Ave 20904 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 Yes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse US Army other it of Health and Mental Hyg If itam 27 is marked other or other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 Is marked ott Adolph Avery Sally O'Riggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Viti/guardian 11921 Rockville Pike 3rd Fl. Rockville MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Importent: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 10-25-2005 Beltsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service m01358 933 Gist Ave Silver Spring MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 hours Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached f o 9 Unknown 9 Unknown 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Senile Dementia 3 ☐ Probebly 4 ⊠Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 1 Yes 2 No Division of Vital To the Hospital or Attanding Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 및 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22780 10-20-2005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter M. Schissler MD 7500 Greenway Ctr. Dr. Greenbelt MD 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Physici /Medic		1. Decedent's Name (First, Middle, Last) Doris E.	Vaeth					2. Date of C Octobe		2005 ^{ear}	3. Time of Death 11:30 Р м
	Examin		4a. Facility Name (If not institution, give stree	·				Location of D			County of Dea	
	Funeral		3810 Courtleigh Dri 5. Social Security Number 6. Sex	7. Age ((In yrs. last birthday)	If Under	1 Year	If Under 24	Hrs. 8. Date of E		Baltimo	rthplace (State or Foreign
	Director		212-18-0937 1 I M	20 X F 84	Yrs.	Months	Days	Hours N	Septembe			Maryland
	land W		Usuel Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Lo	cation						10d. Inside City Limits
	Mary B-f sh	tor	MD Baltimore	:	Randa11	stown	1					1 ☐ Yes 😥 No
	or 28	Direc	10e. Street and Number			10f. Zip	Code			10g. Cit	izen of What C	ountry?
	s 23a	erai	3810 Courtleigh Dr	ive Vas Decedent Ev	or in U.S. 12		21133				d State	es of America
980	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married	Amed Forces? Yes 2 No f Yes, Give Year or Dates:		f Yes, specific Yes	cify Cubai	Specify:	? (Specify Yes or Nuerto Rican, etc.)	40-	Black, Wh	ite, etc.
21215-0036	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade co.	n mpleted)	16a. Dece (Give	kind of wo	rk done a	luring most of	working	16b. Ki	ind of Business	s/Industry
12	within ene. then	dmo	Elementary/Secondary (0-12) (College (1-4or 5+)	life.	DO NOT us	se retired,)	_			
	Hygie other ent,	Be Co	17. Father's Name (First, Middle, Last)	U	Home	макет	-	18. Mother's	Name (First, Midd		Sumame)	
/lan	uld be Mental Irked	To B	Howard Crovo					Henrie	tte Ray			
Maryland	l 2 sho and I is me		19a. Informant's Name/Relationship (Type, 19a) Deborah A. Byrd	Print) (Daughte		•			r Rural Route Num			
	1 and Health tem 27	*	20a. Method of Disposition	(Daugnte	20b. Place of Dispo	sition (Nar	ne of		Parkvil Date	-	cation - City o	
<u></u>	Pages ent of nt: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		cernetery, crea Lake View	-		´ I	/26/05	V.		Maryland
Baltimore,	permit. Departm Importe any inju		21. Signature of Experal Service Licensee		22	2. Name an	nd Addres	s of Facility L	oring By	ers F	uneral	Directors,In
			23a. Part. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused th								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ac	ute	M	40	cou	olial	Lu	land	nset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	A 6	J.	*		,)	
		er	Sequentially list conditions, b. — b. — cause. Enter Underlying	Due to lor as a	consequence of):	<u>eeu</u>	NU	on				
/	cuted	Examiner	Cause (Disease or injury that initiated events)							
Ö,	icate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to (or as a	consequence of):							
8760,	cate b physic the b	dicai	d									
Box 6	death certific e attending p od for use as t	n/Me		f yes, outcome of		75-1					23d. Date of de	elivery
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P. 0.	The law requires that the ste has been signed by the bage 2 should be detache	Phy	9 ☐ Unknown Part II. Other significant conditions contributions	uting to death but	not resulting in the u	nderlying c	ause dive	en in Part I	23e. Dio	tobacco u	se contribute t	o the cause of death?
Records,	uires l signe	d by		3								robably 4 Unknown
000	sw requir s been si s should	Completed							24a. Wa		24b. Were a	utopsy findings available
Re	The la	шо								opsy formed? 2.2400	prior to death?	
Vita	Physician: r this certifice ral director, p	Be	25. Was case referred to medical examiner?	itali			Other		Death (Check only			
of	Physic ruthis or rall dir	- T	1 ☐ Yes No Hosp 27. Manner of Death 2	1 Inpatient 8a. Date of Injury	2 ER/Outpatier 28b. Time o		Othe 28c. Injury	4 Nursin	ng Home 5 Res			ecify)
ion	nding tth. :: Afte e fune	ation	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	(ear) Injury	М	Work	? ′es 2 □ No			,	
Division of Vital	r Atter ter des irector	Certification;	3 Suicide 6 Could not be determined 2	8e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory	, office			(Street and		tural Route Number,
	pitel o		Con Contifice 4 Contifuing Physicia	- T- 4b - b - 4 - 5	- Secondadas das S							
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	On the basis of each of the basis of each of the basis of each of the basis of each of the basis	xamination and/or in	vestigation.	at the tim , in my op	e, date and pi inion, death o	ace, and due to the occurred at the time	e cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	^		290	. License	number		29d. Dat	e signed (Mon	th, Day, Year)
)			1 Haw of	2			Das	5112	,	10	1501	2005
	10		30. Name and address of person who complete the complete	ted cause of dea	th (Item 23a) (Type,	Sili Sili	01	01 (Juing	8 L	2111	7
	Sta		31. Date filed (Month, Day, Year)	32%Registrar	s Signature	use			0	<i>y</i> -11.	1611	
	Registr	ar	OCT 2 5 2005	Blacker	12. 10							

			1 = State Amend Item 5 Registre Amend Item #	State of Maryl	and / Depa	rtment of F	lealth and I	Mental Hygie	2000 .	34459
	Physici /Medio		1. Decedent's Name (First, Middle, Last	"Yttill		Mary V	itilio	2. Date of Death	M 2005	3. Time of Death
	Examir Funeral Director	ner (XIVI	a-111aru	yrs last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Dath of Birth	n/a 9. Birthpla Countr MI	ce (State or Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	Cockey				100	d. Inside City Limits 1 ☐ Yes 2 ▼No
	with the I	Funeral Director	10e. Street and Number 10535 York Rd.	imore	Cocke	10f. Zip Code	21030	10g.	Citizen of What Country	
036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23a or 28a-f show event. I're Medical Exertifier must be incillised at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No lf Yes, Give Year or Dates:	l:	Vas Decedent of H	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americar Black, White, et	c.
21215-0036	within 72 ho ene. then "natur ne Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4 or 5+) n/a	(Give	ent's Usual Occup kind of work done o OO NOT use retired	durina most of wor	king 160	c. Kind of Business/Indu	
Maryland 2	should be filed and Mental Hygi marked other imatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Louis Merlo	117 0	50	diiisti ess		a Teresa		mig
	es 1 and 2 sof Health ar		19a. Informant's Name/Relationship (T) Anthony Vitilio/so 20a. Method of Disposition 1 □Surial 2 □Cremation 3 □I	n 20 Removal from State	12 L b. Place of Dispos cemetery, crem	exington Sition (Name of place of the place)	Dr., Sh	rewsbury Date 200	Palta	n, State
Baltimore,	permit. Pag Department Important: I eny Injury o once.		4 □ Donation 5 □ Other (Specify,		22	Name and Addres	er Cem. ss of Facility n Funera onia Rd.	10/26/05 I Home of Timoniu	Balto., M Dulaney V m, MD 2109	
8760,	Prinysician and // // // // // // // // // // // // //	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a conduct.) Due to (or as a conduct.) Due to (or as a conduct.)	sequence of):	or the mode of dyin	g, such as cardiac	or respiratory arrest,	lr	oproximate nterval Batween Onset and Death
Box 6	death certifica e attending ph id for use as ti	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month D	ay Year
rds, P	signed signed d be de	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the un	derlying cause give	en in Part I.		co use contribute to the	1/
al Records,	i: The faw requicate hes been r. page 2 shoul	Completed						24a. Was an autopsy performed 1 ☐ Yes 2 ☐	prior to comp death?	y fin≘ngs available bletion of cause of □ No
of Vital	iding Physician; Th th. : After this certificate funeral director, pag	To Be	1/2165 2 140		ER/Outpatient		er: 4 🗆 Nursing H	th <i>Check only</i> one one one one one one one one one one	6 ☐Other (Specify)	
Division o	or Attending Patter death. Director: After to by the funera	Certification;	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Worl	yat k? Yes 2 □No	28d. Describe how i	njury occurred	
Divi	Ital or Attendi irs after death rel Director: A led in by the fu		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)			City or Town, S		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one)	sician: To the best of my iner: On the basis of examand manner stated.	knowledge, death nination and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner as state and place, and due to th	ed. le cause(s)
	To To COL	2	29b. Signature and Tiple of certifier Heart	Boure	MI	29c. License	2 2 5 1	Z (1)	Date signed (Month, Da	y, Year)
	6		a0. Name and address of person who co	DOC!	MYPR	SHUE	fund :	3.0A	àrcen (SE
1 4 T	Sta Registr	-	31. Date filed (Month, Day, Year) OCT 2 5 20	32 Aegistrar's Si	gnature	all I	•		•	

			1 = For State Registrar	S	State of M	Marylaı				Health a <i>Death</i>	nd Me		gien g Reg. No.	005	34460
•	Physici /Medio Examin	al	1. Decedent's Name (First, Mice DELORES 4a. Facility Name (If not institute)	WITH			1.1	4b. Cit	ty, Town,	or Location of	Death	2. Date of De Month	Day 4c. C	Year According to Deat N/A	3. Time of Death
2	- Funeral Director		5. Social Security Number 216-34-7657 Usuel Residence of Decedent	6. Sex	2/2 F	Age (In yrs	last birthda Yrs.	Month	der 1 Year s Days		4 Hrs. 8	B. Date of Bri (Month, Da 03/11	th v. Year	9. Birt	thplace (State or Foreign buntry) RYLAND
1000	death with the Maryland me 23a or 28a-f ehow rmat be notified at	ctor	10a. State 10b. Cour	ty N/A			ity, Town or BALTI		CI	ГY					10d. Inside City Limits 1 X Yes 2 □ No
3	th with th 23s or 26	al Director	1341 WOODY:	EAR S	TREET			10f. 2	Zip Code 212	17			-	en of What Co ISA	ountry?
-0036	hours after deal tural', or iteme	by Funeral	11. Marital Status 1 □ Never Married 2 M 3 □ Widowed 4 □ Divorc	arned	Was Decede Armed Force 1 Yes 2 (If Yes, Give Year or Date	XNo	J.S. 1:		cedent of pecify Cub	Hispanic Origon, Mexican, Specify:	in? (Spec Puerto Ri	fy Yes or No can, etc.)		4. Race - Ame Black, White Specify: B	
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oxes aryland	be file stal Hyg of othe	To Be C	17. Father's Name (First, Middle THOMAS Me	CCALL						18. Mother MAF	's Name (First, Middle CANN	Maiden S	iumame)	
Delot imore, Mar	is 1 and 2 strength are item 27 is other trau		ADAM J. WIT 20a. Method of Disposition 1 Burial 2 □ Crematio	HERSP	OON /	20b.	BAND Place of Dis	134 sposition (A	1 W(lame of r other pla	OODYEA	AR S'	Г., В	ALTI 20c. Loca	ation - City or	MD 21217 Town, State
Baltim	permit. Page Depertment of Important: If any injury or once.		4 Donation 5 Other 21. Signature Funeral Service		A. A	VIII.	OODLA	22. Name	and Addr	FERY 1 ess of Facility	НО	WELL	FUNE	RAL H	E CO., MD OME 21207 IMORE, MD
8760,	Physician //Medical Examiner burial-transit sthe purial-transit	dical Examiner	23a San Enter the Isease, shock or he Italiure. Limited a late of Late (Pinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or complications only one of the control only one of t	Due to (or	as a conse as a conse	quence of):	enter the m		ing, such as c		respiratory a	rrest,	erest	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68	ne death certif the attending thed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c.	. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Fet tat time of	al death	3 □Ectopic 5 □ Other (су			23	3d. Date of del Month	ivery Day Year
rds, P.	quires that the signed by and be detacted	d by Ph	Part II. Other significant cond	itions contri	buting to deat	h but not re	sulting in the	o underlying	g cause g	ven in Part I.			obacco uso		the cause of death?
al Reco	ilcian: The law requ certilicate has been rector, page 2 shoult	Completed	1									1 Yes	osy ormed? 2 12 No	prior to death?	utopsy findings available completion of cause of 2 No
Ž	nysicia nis certi I directo	To Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 ☒ No	Hos	spital:] ER/Outpat	tient 3	DOA O	haa		Check only o		☐Other (Spec	cify)
rision o	Attending Ph death. ictor: After th y the funeral	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation	28a. Date of I (Month,	Injury - At !	28b. Time Injury	М		Yes 2 □ N	1	d. Describe	Street and		ural Route Number,
Oiv.	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 💢 Certif	vina Physic	building,	etc. (Spec	ify)	ath occurre	ad at the t	ime date and	place, an	City or To	wn, State)	and manner as	stated
	the Hi thin 24 the Fi mplete	Medicai	one) 2 medic		and manner	s or examin stated.	ation and/or			opinion, deatr	1 occurred	at the time,		signed (Monti	to the cause(s)
	T W S			5					89	532	7	(27-6		al. 2005
0%	6		30. Name and address of pers	n wh	nom '	of death (Ite	om 23a) (Typ	pe, Print)	101	Dary	land	Gen	era l	Ho	Rital
	Sta Registi		31. Date filed (Month, Day, Ye	5 200 ¹	Si	istra s Sign	nature	book	1						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Walters Janet 2005 OCT ·45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7848 Milkshed Place **Elkridge** Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 M 2 KF 150-20-3098 Director 76 1929 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow free must be notified at Completed by Funeral Director 1 ☐ Yes 2 X No Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 7848 Milkshed Place Itams 23a 21075 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Itams 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No traumatic event, the Medical Exar White 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Williams Elsie Bird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau 200ce. Harry G. Walters/husband 7848 Milkshed Place Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/20/05 Baltimore, MD 21. Signature Fur eral Service License ²²Cremation Society of Maryland, Inc. DAWN McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MOTASTATIC, RECURRENT OF ESOpliagus **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 robably Completed 1 Yes 2 No 4 DUnknown)isease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 25. Was case referred to medical examiner? V Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or within 24 hours after death.
To the Funerel Director: After Funerel Director: After Funerel Director After Funerel Director After Funerel Director After Funerel Director After Funerel Director After Fun 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TTENDING D16200 OctoBER 20, 2005 PHYSICIM 5 use of death (Item 23a) (Type, Print) NORBERTO M. MACHIRAN, M.D. 720-C MAIDEN CHOICE LA. CATENSVIlle, MD 21228 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month October 19, 2005 Eleanor Christine Wallace 0310 /Medical 4a. Facility Name (If not institution, give street and number)
Harford Memorial Hospital Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Havre de Grace 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 21, 1926 9. Birthplace (State or Foreign **Funeral** 219-16-4704 1 ☐ M 2 🖾 F Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at Bel Air Harford Director Md. 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or items 23a 21014 U.S.A. 2823 Henley Drive death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. shifter 27 is marked other then "natural", or ite Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white þ Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary (unknown) Wojichowski Casper Wojichowski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tra 2823 Henley Drive, Bel Air, Md. 21014 Thomas A. Wallace/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Bayview Crematory 10/22/05 Baltimore, Md. 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Decamo 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetrand Death Immediate Cause (Final **Physician** disease or condition resulting in death) eve DVD Vac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 🗌 Yes 2☐No 3☐ Probably 4 ☐Unknown page 2 s. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed' certificate 1 ☐ Yes 2E 100 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1. Inpatient 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deam (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar 2005

			1 - For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	ealth a D <i>eath</i>	and Men		ene g. No.	5	34463	
	Physici	an	1. Decedent's Name (First, Middle,	,						ate of Death Month	Day	Year	3. Time of Death	
	/Media	al	Alice Mae Wi							tober	22 2	005	4:00 A M	
	Examir	er	4a. Facility Name (If not institution, 11885 Scaggsvi		mber)		4b. City, Town, or		f Death		4c. County			
	Funeral			. Sex	7. Age (In yrs. I	last birthdav)	Fulton If Under 1 Year	If Under 2	24 Hrs. 8 D	ate of Birth	Но	ward	lana (State or Foreign	_
н	Director		212-20-2067	1 □ M 2 🛣 F	80	Yrs.	Months Days	Hours	Min. (/	Month, Day, 1 ine 20			lace <i>(St</i> ate or Foreign itry) Vland	
	p.		Usual Residence of Decedent				11			20,	1725	rai	yrana	_
	arylar show	_	10a. State 10b. County			y, Town or Lo						11	0d. Inside City Limits	
	8a-f	Director	MD Howard			Fulton							1 ☐ Yes 2 🙀 No	_
	with t	급	10e. Street and Number				10f. Zip Code			100	g. Citizen of W	Vhat Coun	try?	
	eath	eral	11885 Scaggsvil		edent Ever in U.	S 13 U	20759 Was Decedent of Hi		rin? (Specify)	Voc or No	USA 14 Page	- Americ	on todion	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show appringury or other traumatic avant, I'ps Mcdical Examinar must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	rces? 2KNo /e	1	f Yes, specify Cubai	Specify:	, Puerto Ricar	n, etc.)	Blac	k, White, e	etc.	
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Ē	be fill	Be	17. Father's Name (First, Middle, La	st)							iden Sumam	e)		
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Maryland	d 2 sl th an th an traur		19a. Informant's Name/Relationship John D. Wilkers		nd		g Address <i>(Street</i> a 5 Scaggsv					State, <i>Zip</i> 2075		
ā,	Heal Heal tam 2		20a. Method of Disposition		20h Pl	lace of Dispo-	sition (Name of	T	Date	-	c. Location -			-
Baltimore,	Pages ent of nt: If i		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		natory or other place	- 1	0/26/2		lkrida			
를	mit. F partm sortar / inju	İ	21. Signature of Funeral Service Lie	• •			. Name and Address	,						=
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			23a. Part 1 Enter the disease, or co shook, or heart failure. List or	mplications that c	aused the death	. Do not ente	er the mode of dying	, such as c	ardiac or resp	oiratory arrest	t,		Approximate Interval Between	_
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	/Medical Examiner		resulting in death)		or as a consequ	ence of):								_
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C. Box	ne death certifi the attending hed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1☐Live b	come of pregnar irth 2 ☐ Fetal ant at time of de own	death 3 🗆	Ectopic pregnancy Other (specify)				23d. Date Mon	of deliver	y Day Year	
	that the ed by detac	/ Ph	Part II. Other significant conditions	contributing to de	eath but not resu	lting in the un	deriving cause give	n in Part I.	2	3e. Did tobac	co use contri	bute to the	a cause of death?	
ords,	w requires that the de been signed by the should be detached	Ð.	Sepsis										abiy 4 ⊠Unknown	
	The lay ate has page 2	Completed	Urinary Tract	Infection	on					4a. Was an autopsy performed ☐ Yes 2	Dr.	ere autoprior to comeath?	sy findings available pletion of cause of	
<u> </u>	ysician: is certific director,	Be (25. Was case referred to medical examiner?				7707		of Death (Che	ck only one)				-
=	sir din	2	1 ☐ Yes 🔏 No 27. Manner of Death			ER/Outpatient	3 DOA Other	. 4 🗆 Nurs	sing Home 5	Residenc	e 6 Othe	(Specify)		
DIVISION	ending Feath. or: After the funera	cation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	ion	h, Day Year)	28b. Time of Injury	28c. Injury Work' M 1 □ Y	at ? es 2 □ No		escribe how	injury occurre	d		
N N	tal or Att rs after d al Diract ed in by	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place	of Injury - At hor ng, etc. <i>(Specify)</i>	me, farm, stre	et, factory, office		28f. Lo	ocation (Stree ity or Town, S	at and Number State)	r or Rural	Route Number,	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edical	29a. Certifier 1	Physician: To the aminer: On the ba and mann	isis of examinati	vledge, death on and/or inv	occurred at the time estigation, in my opi	e, date and nion, death	place, and du occurred at t	ie to the caus he time, date	e(s) and man and place, ar	ner as sta nd due to t	ted. the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	11 100			29c. License				Date signed		-	
			- Lances	1100			D5398	o /		00	ctober	24,	2005	
	10		30. Name and address of person wh Kenneth Geh, MI	300 P	armory P	lace S	Print) Suite 3G	Balti	Lmore,	MD 212	201			
	Sta Registra		31. Date filed (Month, Day, Year)	32. R	egistrar's Signati	nre nsee	20							

			1- State of Maryland / Department of Health and Mental Hygiene 05 34464 Certificate of Death Registrar
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2. June of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL 4b. City, Town, or Location of Death SILVER SPRING MONTGOMERY
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) Yrs. 1 Months Days Hours Min. 5 / 2 / 6 9. Birthplace (State or Foreign (Month, Day, Year) 5 / 2 / 6 9. Birthplace (State or Foreign (Month, Day, Year) 5 / 2 / 6 9. Birthplace (State or Foreign (Month, Day, Year) 5 / 2 / 6 9. Birthplace (State or Foreign (Month, Day, Year) 5 / 2 / 6 9. Birthplace (State or Foreign (Month, Day, Year) 1 M S S S S S S S S S S S S S S S S S S
	Maryland a-f show ified at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits
	th with the 23a or 28a	al Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 United States
036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show he Mazileal Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No Specify: Specify: Specify: BLACK
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla tt of Health and Menhall Hygiene. If them 27 is marked other than "natural", or tlems 23a or 28a-f show or other traumatic event, the Madical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. College (1-4or 5+) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Smithsonian Lostitution
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M.	To Be C	17. Father's Name (First, Middle, Last) LEE ROZELLE WHITE SR. 18. Mother's Name (First, Middle, Maiden Sumame) VERTA QUARIES
_	1 and 2 she Health and em 27 Is m ither traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr ottog.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary: crematory or other place) 20c. Location - City or Town, State
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility B.K. HENRY FHC. INC. WGSHINGTON DC. 20002
	ากระเรลก		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) Due to (or as a consequence of):
V '0	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate ause. Litter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
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О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1
rds, P.	w requires that the base of signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ØUnknown
		Completed	24a. Was an autopsy findings available autopsy performed? 1 Yes 2 No 1 Yes 2 No
f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No
	ting After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred
Division	il or Attendii after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th withir To th comp	Me	29b. Signature and tipe of certified 29c. License number 29d. Date; signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN J. SCHWARTZ 11125 POCKVILLE PIKE MD. 20851
	sta Registr	te ar	31. Date filed (Month, Day, Year) OCT 2 5 2005 32. Redistrar's Signature

			1_ For State	State of Maryland / Dep		Mental Hygie	79 005	31.1.65
			Registrar 1. Decedent's Name (First, Middle, Last		ertificate of Death	Reg.	No.	34400
	Physici /Medi		Janie Loui	. 011	S	2. Date of Death Month	8 OS	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of De		4c. County of Death	
	Funeral		HOLY CROSS 5. Social Security Number 6. Se	x 7. Age (In yrs. last birthda		rs. 8. Date of Birth	MONTGO 9. Birthpl	
	Director		578-38-6013 10 Usuat Residence of Decedent	M 20 F 76 Yrs.	Months Days Hours Mi	n. (Month, Day, Ye	29 CHar	ace (State or Foreign try) Diette N.C.
	ryland how		10a. State 10b. County	10c. City, Town or	Location		10	Od. Inside City Limits
	he Mar 28a-f a	ector	MD, P.G.	FORT	Washingto			1 ☐ Yes 2 No
	3a or	Funeral Director	12622 MacDi	FF Drive	10f. Zip Code	10g.	Citizen of What Count	try?
	r deat	Iner	11. Marital Status		B. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - America Black, White, e	an Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-1 ahow any injury or other traumatic event, Ira Medical Exartinar must be rediffied at once.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 Mi No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: 2	OCK
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ğ	be filed stal Hygi of other evant, I	Be C	17. Father's Name (First, Middle, Last)	1.		ame (First, Middle, Maid		16 0,
Maryland	should the marked umatic e	2	19a. Informant's Name/Relationship (T)	liams	Eva	Mae S	Tratfo	ord
	and 2 s ealth an n 27 is r		Laura adams	Idone uma las	iling Address (Street and Number or It			20744
Baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b. Place of Disposer cometery, critical states	position (Name of ematory or other place)	Date 20c.	Location - City or Tov	
Ħ.	permit. Page Department Importent: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Harmon	ny Memorial 101	129105 La	ndover, m	
Ba	Depariment Department of the partment of the p		120 Disk	EMW M01178 (22. Name and Address of Facility Chance FHC.	INC. 420 1	of Street	11.E.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	cations ha caused the death. Do not en	O-M 1-1 O-11			Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Preomonia			17	Onset and Death
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Box	that the death certified by the attending detached for use as	by Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month	y Day Year
O.	hat the od by the detache	Phys	9 ☐ Unknown Part II. Other significant conditions cor	9 Unknown		22. 2:11.		
Division of Vital Records,	8 5 8		AIDS	encoung to death but not resulting in the	underlying cause given in Part I.	1 Yes	use contribute to the	
900	ne law requir has been sl ge 2 should I	Completed				24a. Was an	24b. Were autop:	sy findings available
E E	ysician: The is certificate hadirector, page	Com		-		autopsy performed? 1 ☐ Yes 2 € N	death?	pletion of cause of □ No
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סר	ding Phy h. Alter this funeral o		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time (Injury)	THUISING	Home 5 Residence 28d. Describe how in		
SIO	or Attanding Physician: ifter death. Diractor: Aler this certifica in by the funeral director.	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐ No			
<u>≥</u>	al or Attandi s after death. i Diractor; A id in by the fu	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	281. Location (Street a City or Town, Sta	and Number or Rural I ite)	Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowledge, dea ler: On the basis of examination and/or in and manner stated	th occurred at the time, date and plac	e, and due to the cause	s) and manner as stat	ted.
	To the Vithin 2 To the Complet	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		ate signed (Month, Da	
	⊢s⊢ó		Falleinne Ac	Societ	D0061768		118105	ay, rear/
	6		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	. Print) 1500 Forre	ST Glen	Road	
	Sta	10	FADIENNE SO 31. Date filed (Month, Day, Year)	acqueline Sant	el Silver S	pring, m	1D. 209	10
20	Registr		00T9 F 20	A to	Carles			

State of Maryland / Department of Health and Mental Hygiene 34466 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10-19-2005 Mary Ann Wheeler 12:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Woodstock 10600 Davis Ave, Lot C19 Baltimore If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) 1 ☐ M 2 🛣 F Hours 259-94-0216 Director 51 12-6-1953 GA Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or iteme 23e or 28e-f ebov other traumatic event, the Madical Examiner must be notified at 28e-f show 10d. Inside City Limits Director MD 1 ☐ Yes 2 No Baltimore Woodstock 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10600 Davis Ave, Lot C19 Completed by Funeral 21163 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other then "nery injury or other trauments." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Edward Alexander 2 Cleo Mize 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne E. Wheeler / Husband 10600 Davis Ave, Lot C19; Woodstock, MD 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 10-23-2005 Stevensville, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licensee Tark al MO13571 Second Ave SW; Glen Burnie, MD 21061 abortic chie lung Disservand Death 23a. Part1. Ent see disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition U mic **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 2 No 3 Probably 4 Unknown been s 1 Tes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 2 No 1□ Yes 2□ or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only og Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Certification: To After this 5 lesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death 2 Accident 1 🗆 Yes Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after 4 Homicide To the Hospitel To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MIN Show may Edward 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COVET 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar 2 5 2005

			1 - State Registrar	tate of Maryland	d / Depa	artment of F rtificate of	lealth and	Mental Hyg	iene Legible.	34467
	Physici /Medic	al	Decedent's Name (First, Middle, Last) Roger Rene A. Fecility Name (If not institution, give stre	Waterstreet	, Sr.	4b. City. Town. o	or Location of Deat	2. Date of Deat Month Oct. 21	h Day Year	3. Time of Death 6:45 A
	Examir Funeral Director	er	3815 Longley Road 5. Social Security Number 6. Sex 215–26–4325		as <i>t birthday)</i> Yrs.	Abingd If Under 1 Year Months Days	on		Harfor	
	th the Maryland or 28a-f show a notified at	Director	Usuel Residence of Decedent 10a. State 10b. County Maryland Harford 10e. Street and Number		, Town or Lo			1.	0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐No puntry?
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Maryland 21215-0036	filed within 72 ho Hygiene. thar than "natura ant, Ire M. of call	Completed	15. Decedent's Educati (Specify only highest grade or Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	Shoe Manuf	,
_	0 = 0 5	To Be	Fred Edward Wat	terstreet			Lucy	Adrienne	Cruye	
, Mar	and 2 sh saith and n 27 is m ar traum		19a. Informant's Name/Relationship (Type, Phyllis Waterstreet,	*				i <i>ral Route Number,</i> ingdon, M	City or Town, State, 2 D 21009	Zip Code)
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic e.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Fermation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	metery, crei	sition (Name of matory or other place	1		20c. Location - City or Towson, Ma	- CO.
Balti	permit. Departrimporta Importa any inju		21. Signature of Funeral Service Uncersee		22 MC	Name and Addre	ss of Facility neral Hor	me, P.A.		
60,	Physician /Medical Examiner	cal Examiner	23a. Part1. Enter the scease, or complicate shock, or heaft failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	ence of):	er the mode of dyin	4	c or respiratory arre	st,	Approximate Interval Between Onset and Death
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ds, F	w requires that been signed b should be deta	by	Part II. Other significant conditions contrib	uting to death but not resul	ting in the u	nderlying cause giv	en in Part I.		acco use contribute to	the cause of death?
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-	g Phys er this ieral di	Certification; To Be	1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	R/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing H	th Check on 2 & lome 5 Mesider 28d. Describe hor	nce 6 Other (Spec	ify)
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4	SY		30. Name and address of person who comp	eted cause of death (Item	23a) (Type,	Print) Hi Sir	n, MD 7	8		
	Sta Registr		31. Date filed (Month, Day, Year) 2005	32 Registrar's Signate	ite ear	and I				

			State of Maryland / Department of Health and	•	_	21160
			1 - Stete Certificate of Death		, No. UUJ	34468
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Rosalie Wiggins 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deal	001	23 ZOO 4c. County of Deat	
	Exami	ner	Sinai Hospital of Baltimore Baltimore		N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs			hplace (State or Foreign
	Director		212-44-8007 62 Yrs.	11/28/		rginia
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
,5	death with the Maryland ms 23e or 28a-f show rms t'e notilited at	ţċ	MD Baltimore Gwynn Oak			1 ☐ Yes 2 ☐ No
Wiggins	ith the or 28;	Oirec	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?
3	s 23e	rai	6803 Carol Road 21207	Casaire Van as No	USA 14. Race - Ame	ricae Indian
-	fter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Ves 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify:	to Rican, etc.)	Black, White	e. etc.
1	O36 ours a	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates:			rican
Rosalle	21215-0036 d within 72 hours af giene. er than "netural", or the Wolcal Exe	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking Fr	Sb. Kind of Business/	
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7	Hygi other	BeC		me (First, Middle, Ma	iden Sumame)	
2	Maryland od 2 should be file lith and Mental Hy 27 is marked oth	ToB	Alonzo Dixon Jr. Carrie	e Dixon		
3	Z sho and is my		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship)	ural Route Number, C	ity or Town, State, 2	(ip Code)
Knowin	Baltimore, Maryland 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23e or 28a-1 show any nivry or other traumatic event, the Medical Examiner must be notified at once.		Charles J. Wiggins/Husband 6803 Carol Road G4 20a. Method of Disposition (Name of	ynn Oak	Marylai c. Location - City or	nd21207 Town, State
	Baltimore, permit. Pages 1 ar Department of Healmportent: If item any injury or other pince.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State			, Maryland
to thent	attir nett. P sortme oorten / injur		21. Signature Funeral Ser los Licensee 22. Name and Address of Facility Wy			
70	W FORES		Fright William 9200 Liberty Ros	ad Randa	11stown	
1			231. Part1. Enter the disease, or con plantions that carsed the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only the cause on each line.	c or respiratory arrest	t,	Approximate Interval Between Onset and Death
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	Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and tin by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	very
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	ital an: T	Be Co	25. Was case referred to medical 26. Place of Dec	1 ☐ Yes 2 ½ ath (Check only one)	No 1 Yes	202110
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	ision ttend death ctor: /	icat	3 Suicide 6 Could not be	28f. Location (Street	et and Number or Ru	ral Route Number,
	Div A after after Directory	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, S		
	lospite hours unere		29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place			
	Division of Vital Rec To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: Atter this certificate has completely illied in by the funeral director, page 2	Medical	one) and manner stated. 29b. Signature and title of centifie). 29c. License number		. Date signed (Month	
	T Will		RES-000	0	bab = 22	2005
	56		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	401 W. Bel	reder A	venue
	\'		Andrew A. Nelson MD Sinai Hospital of Baltimore ?	Baltimore,	M) 21	215
		ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature			
	Regist	rair	OCT 2 5 2005 Marker & Marker &			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 15 Registrer Amend Item #10b-10f Per FII C84911/02/05 JII 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death **Physician** OCTOBER 20 WOLFTHAL 2005 2:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CASEY HOUSE MONTGOMERY ROCKVILLE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Yrs Director 093-14-4158 88 08/26/1917 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 10d. Inside City Limits Montgomery BALTIMORE Director Yes 2 No Silver Spring OWINGS MILLS 10e. Street and Number 3746 S. Leisure World Blvd 10g. Citizen of What Country? 20906 9314 FITZHARDING LANE 21117 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE ≥ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Itam 27 is marked oth any lighty or other traumatic avent poice. Be **ROSENBERG** HARRY SADIE WOLFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAX WOLFTHAL / SON 9314 FITZHARDING LANE-OWINGSMILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State JUDEAN MEMORIAL 5 ☐ Other (Specify) 10/23/2005 OLNEY, MD GARDENS 21. Signat uneral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MASSIVE CVA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ڄ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics Hospital: ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: Division To the Hospitei or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No Diractor: 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hin 24 hours after the Funeral Dira 1 Certifying Physician: To the best of my knowledge death ancience at the time, date and place, and due to the eause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature ar 29c. License numbe 29d. Date signed (Month, Day, Year) 2005 Û o completed cause of death (Ite 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 5 2005

Registrar's Signature

Hui Ping Xiang 05-7140 AKG **Physician** /Medical

with the Maryland

death

Funeral

Director

Worle

ir than "naturel", or iteme 23s or 28s-f ehor tre Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than naturel, or Item eny Injury or other treumatic event, the Medical Examinars

Physician

/Medical

Examiner

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page 2 should

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After this certification

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certificate be executed physician and the burial-transit

Box 68760,

P.O.

Division of Vital Records,

Physician:

or Attending

To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A

filled

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Hui Ping Xiang 22, 2005 October 0 12:01 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1X M 2□ F Months Days Hours Min 071-90-2095 31 1974 China Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 X Yes 2 □ No Director MD Prince George Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6821 Ammendale Way 20705 China Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 N Married Specify: Asian 1 Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Student University of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dexin Xiang Yevu Zhang P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daifeng Han 6821 Ammendale Way, Beltsville, Maryland 20705 20h Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory Nov 7, 05 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Lice se 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faffure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death MUMPLE DUJURIO Due to (or as a consequence of): Sequentially list conditions, if any, loading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Use to for as a nonsecuence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 2 1 Department 2 ER/Outpatient 3 DOA 28c. tnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending 23:078 2 No Druce occión, couines witherse 1 ☐ Yes investigation 10-21-05 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide FODDWAY Pauper HILLED COLUMN P.9 COLUM 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME October 23, 2005 Uninte 1h 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 111 Fenn Street Baltimore, Maryland 21201 (XVY) PUTO KUR M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DE SEL OCT 2 5 2005

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 05 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician October 5200s Year 1:48P Alphonso Adams, Jr. R. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors' Hospital P.G. Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/25/1927 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∏ M 2□ F Months Days Hours Washington, DC 78 Director 578-28-6154 Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location wode 10d. Inside City Limits unt by notified at P.G. Lanham X☐Yes 2☐No Director 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 10401 Buena Vista Avenue 20705 USA or iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

N☐ Yes 2 ☐ No 46-49 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other treumatic event, the Modical Examinary 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. int: ff item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12th Printer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alphonso R. Adams, Sr. Pinkey Wiley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Melba D. Adams - Wife 10401 Buena Vista Avenue; Lanham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State Harmony Memorial Pk 10/11/2005 Landover, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service II censee 22. Name and Address of Facility Freeman Funeral Services P.O. Box 416; Suitland, Maryland 20752 23a. Part I Sitter the disease, of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 3 WKS /Medical Hemorrhagic stoke. Due to (or as a consequence A) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit 3 mKs The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached sate hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy performed? 2 No 1 Yes the Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the hest of my knowledge death occurred at the time, date and place, and due to the daese(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) amali Lucy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7305 Green belt mo Hanover P JAMALI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 1 2005

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34472 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** MYRNA FRANKLIN OCTOBER 9,2005 ADAMS /Medical 3:40 pm 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NURSING HOME
Age (In yrs. last birthday)
Months Days FUTURE PINEVIEW CARE PRINCE GEORGES CLINTON If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Hours Min Director 578-<u>56-7406</u> WASH. DC 3-26-1942 Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental Hygiene. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at CHARLES WALDORF Director MD 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4388 EAGLE COURT Funeral 20603 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: à Specify: BLACK 3 ☐ Widowed 4 🙀 Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. 12th CHIEF OF DOCKETS SECTION DEPT. OF TRANSPORT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WELBURN M. FRANKLIN RUTH ELIZABETH BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARYL A. FRANKLIN -9919 OLD FORT RD., SON FT. WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM10-14-05 SUITLAND, MD 21. Signature of Funeral Service Licen-22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner lew requires thet the deeth certificate be executed burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) of Vital Records, P.O. Box 68760, physician as the burial Physician/Medical Due to (or as e consequence of): attending p Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown δ should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificete hes 1 Yes 2 No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 ☑ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1045365 OCTOBER 10, 2005

Registrar

State

31. Date filed (Month, Day, Year)

1 1 2005

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of person who completed cause of death (Item 23e) (Type, Print)

B.K.S WALTER A BANKSTON IR

State of Maryland / Department of Health and Mental Hygie 2en 05

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V V Z 3	DIEK A.	יעב	1 = State Registrar	Ce	ertificate of l	Death	Reg. I		J4410
	Physic /Medi Examii	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL	ankst	4b. City. Town, or CLINTON	Location of Death	2. Date of Death Month OCT. 7	Day Year 2005 4c. County of Death PRINCE GE	
Z	Funeral Director	E	5. Social Security Number 5. Social Security Number 6. Sex 1 DM 2 F 7. Age Usual Residence of Decedent	(In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes		place (State or Foreign intry) ORG A
	death with the Maryland ms 23a or 28s-f show rmust by notified at	ector	MD Prince Georges	10c. City, Town or L Agua	500				10d. Inside City Limits 1 des 2 des
		Funeral Director	10e. Street and Number 2 1405 AGUASCOK 11. Marital Status 12. Was Decedent E Armed Forces?		10f. Zip Code 20 Was Decedent of Hi If Yes, specify Cuba	608 spanic Origin? (Spen, Mexican, Puerto F	city Yes or No-	Citizen of What Cou LIS 14. Race - Ameri Black, White	ican Indian,
5-0036	72 hours after naturel', or its dical Exemine		1 Never Married 2 Marned 1 Yes 2 PN Yes 3 Widowed 4 Provorced Year or Dates:	16a. Dec	1 ☐ Yes 2 ♠ No	ation	16b.	Specify: 3/	ack
2121	2 should be filed within 72 hours and Mantal Hygiene. is marked other than "naturel", surmatic event, the Madical Exe	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-4) 17. Father's Name (First, Middle, Last)	lite.	e kind of work done d DO NOT use retired	F	K	Restau	rant
Maryland	should be and Mental I s marked o	To Be		ston, S	ling Address (Street a	18. Mother's Name Ann Ind Number or Rural	MAC V	ARner	p Code)
00-	permit. Pages 1 and 2 Department of Health is Important: If itam 27 if eny injury or other tre 2069.		Deleaches Young 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Disp cemetery, cre		sco Ro	Aguasco atel 20c.	Md. & Location - City or T	20608 Town, State
Baltimore	permit. Pag Department Important: eny injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Christ	Church 22. Name and Addres Adams Fi	s of Facility	4/05 1	AGUASO AGUASOO	M.20608
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death) Due to (or as a	the death. Do not ene.	nter the mode of dying	g, such as cardiac or	respiratory arrest,	ig nii see	Approximate Interval Between Onset and Death
68760,	e as the burial-transit	Medicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):					
Box	ath co	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at till 9 Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver	ery Day Year
ords, P.O.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but	t not resulting in the u	underlying cause give	n in Part I.		o use contribute to the	he cause of death?
tal Rec	ician: The law certificate has b ector, page 2 st	Be Completed	25. Was case referred to medical			26 Place of Death	24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of 2 No
Ϋ́	S S	To B	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatie	nt 3 DOA Othe	26. Place of Death C 4 □ Nursing Hom	e 5 Residence	6 ☐ Other (Specif	ν)
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	4 in nomicide building, etc.	ny - At home, farm, st (Specify)	9AM 1□Y	es 2 🗷 No 28	Bd. Describe how in particular to the control of th	d hit 7 and Number or Rula te) 1100 BI	K
	Hospite 24 hours Funers letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of earld manner state and manner state	f my knowledge, deat examination and/or in	th occurred at the time	e date and place an	nd due to the cause(d at the time, date a	RA. PG. s) and manner as s nd place, and due to	tated.
	To th withir To th comp	Me	29b. Signature and title of certifier	M		.M.E	O	CT. 8, 20	
9	BB		30. Name and address of person who completed days of dea		N STREET,	BALTIMOR	E, MARYLANI	D 21201	
4.	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 2 2005	r's Signature	berle				

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	Dhuoloi.		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
S Section 1	Physicia Medic		Marion Briggs Bostian		October	$^{0}_{10,2005}$	11:00a ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	#		16301 Cedar Lawn Drive	Waldorf		Charles	157 1
	uneral		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday, 95 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birthp	lace (State or Foreign
	irector	-	220-82-9075 1		Sept. 14,	1910 was	hingtonD.
yland	MON		10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limits
Mar	filed	to	Maryland Charles Waldorf				1 ☐ Yes 2X No
h the	or 28,	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
th Wi	23a c		16301 Cedar Lawn Drive 。	20601		U.S.A.	
r dea	eme ar m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
s afte	or la	by Fu	1 Never Married 2 Married 1 Yes 3 No	1 Yes 2 X No Specify:			
hours at	tural' BIES	q pe	Widowed 4 Divorced Year or Dates:	dont's Flouri Convention	105	Specify. Whit	
2 2	edic	olete	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	. Kind of Business/Ind	austry
U KIKIS-UUSO filed within 72 hours after death with the Maryland Hydione	d other than "natural", or iteme 23a or 28a-f show avent, the Medical Examinational be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	emaker		Her Home	2
	othe,	Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
aryland should be fill		To B	Charles Woodard	Mollie	e DeAtl	.ey	
Short Short	ls marked o		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rur	al Route Number, Cit	y or Town, State, Zip	Code)
and 2	Itam 27 is marke			01 Cedar Lawn D	rive, Wa	ldorf, M	1d.20601
es t	if Itan		20a. Method of Disposition UBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposement, cremetery, cre	osition (Name of matory or other place) Memorial Cala	2005	. Location - City or To	
Peges	ury o		t Elbaration C Elbaraty,	1	,,,	ldorf, N	laryland
Dailtimor	Important: If its any injury or of		21. Signature of Funeral Service Licensee	2 Name and Address of Facility Williams Funera	l Home,	P.A.	20640
م م) = e o		1100000	42/0 Hawthorne	Rd., Ir	dian Hea	ad, Md.
			shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
54.	sician		Immediate Cause\\(\mathbb{E}\)inal disease or condition resulting in death) a. ACUTE MYO	CARDIAL INFAC	ection		244RS
4.	ledical aminer		Due to (or as a consequence of):				
		10	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
nted	nsil	Examiner	cause. Enter Underlying Cause (Disease or injury				
у,	n and ial-tra	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
oo / ou,	ysicie e bur		d				
-	attending physicien and for use as the burial-transil	cian/Medical	TEETING.				
DOX	tendir r use	an/A	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	,
. L			1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
ords, P.O.	certilicete has been signed by the rector, page 2 should be detached	Physi	9 Unknown		00 01111		
ies #	signe I be d	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the that TPERTENSION	inderlying cause given in Part I.		o use contribute to the	
	hould	Completed	F1 / 1 C C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1		1 Tes	2 So 3 Prob	ably 4 Unknown
(I)	has b	μ			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
T Pe	, pag				performed	? death? No 1 ☐ Yes	2□ No
OT VITAL	certif	Be	25. Was case referred to medical examiner? Hospital:	Othor	h (Check only one)		
0 E	d d	10	1 Inpatient 2 EH/Outpatie	11 3 DOA 4 Nursing Ho	ome 5 Residence	6 Other (Specification)	y)
ding 4	After this certifice funeral director, p	to	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 Yes 2 No	200. Describe now ii	nary occurred	
DIVISION For Attending	ctor:	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st		28f. Location (Street	and Number or Rura	l Route Number
	d in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)	,,	City or Town, St	ate)	
papite	within 24 hours are local To the Funeral Director, After the completely filled in by the funeral		29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	e(s) and manner as si	tated.
He Ho	he Fr	Medical	(Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
Tot	To the	Σ	29b. Signature and title of certifier.	29c. License number	29d.	Date signed (Month,	
				D28281		10/11/2	200
(gr-sq.		30. Name and address of person who completed cause of death (Item 23a) (Type NELSON BENJERS, 913) PISCAT	Print)	TON MT	9022	-1
M) (NEWSON DENJERO, 713) PISCAT	אנט לה אאשע	, ,,,,,,	J JULY 733	
	Sta		31. Date filed (Monting Tay Year) 2 2005 32. Refistrar's Signature	land.			
. S. A.	Registi	al	There Is	(Delle)			

1 - For State Registrar

			r lease r	State of Maryland	-				•	-	
			1 - State Registrar	,, ,, ,, ,,,		rtificate d				ZUU5	34475
	Physici	an	1. Decedent's Name (First, Middle, Last)					2.	Date of Deatl Month	h Day Yea	3. Time of Death
	/Medic	al	ESTELLE MAMIE		MOX	4h City Town	1 1:		ct.	11, 2005 4c. County of D	5:35 a ^M
	Examin	er	4a. Facility Name (If not institution, give s Hartley Hall Nursi				n, or Location of noke Cit			Worcest	
	Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Ye Months Da	ar If Under 2	24 Hrs. 8.	Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
L	Director		229–05–1850 Usual Residence of Decedent	8	7 Yrs.	Working Bu	yo moule	Fe	eb. 28,	1918 Vi	rginia
	yland yland		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Ba-f st	ctor	MD Worcester	Poce	omoke	City				·	1 X Yes 2 □ No
	with th	Director	10e. Street and Number			10f. Zip Cod			10	og. Citizen of What	Country? USA
	death ms 23	Funeral	1006 Market Street	2. Was Decedent Ever in U.S	i. 13. \		of Hispanic Orig Cuban, Mexican,	in? (Specify	y Yes or No-	14. Race - A	merican Indian,
9	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give		1 Yes, sp <i>ecity</i> 0 1 ☐ Yes 2 2X 1		, Puerto Ric	an, etc.)		/hite, etc. white
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event. The Medical Examinar must be notified at	ed by	3 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual Oc				16b. Kind of Busine	
21.5 21.5	nin 72 In "na Madic	piet	(Specify only highest grade		(Give	kind of work do DO NOT use re	ne during most tired)	of working		160. Kind of Busine	ss/industry
2	filed with Hygiene other the	Completed	4	College (1-40/ 54)	Home	emaker				Domestic	!
and		Be	17. Father's Name (First, Middle, Last) Ray Wessells, Sr.							faiden Sumame)	
Maryland	2 should be and Menta is marked aumatic ev	J.	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailir	ng Address (Str		4.00	Grotor oute Number,	1 City or Town, Stat	e, Zip Code)
	is 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Sharon Sturgis (gra	nddaughter)_						ke City,	
Baltimore,	m 0		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Re	1 000	ace of Dispo metery, cren	sition (Name of natory or other	place)	Date		20c. Location - City	
Ē	perrit. Page Department o Important: If any injury or ance.		4 □ Donation 5 □ Other (Specify)21. Signature of Fune a Service License			Cemete					Virginia
Ba	Dep Imp		Much of D.	Down	H	olloway 03 Lind	MEIson en Ave.	Funer	ral Hor omoke (ne, P.A. City, MD	21851
	*		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	Do not ent	er the mode of	dying, such as c	cardiac or re	espiratory arre	est,	Approximate Interval Between
	Physician	Į ĮĮ	Immediate Cause (Final disease or condition	CEREBROV							Onset and Death
П	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
760,	icate be executed physician and s the burial-transit	cal Ex	resulting in death) Last	Due to (or as a conseque	ence of):						
687	fficate g phys		V d								
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregna	incv			23d. Date of	,
о. Ш	at the dea by the att tached fo	sici	in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown		Other (specify				Month	Day Year
٥.	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use contribute	e to the cause of death?
rds	w requires that been signed b should be deta	ed by							1 🗋 Ye	s 2 0 3 0	Probably 4 Unknown
Records,	e law rec has bee ge 2 sho	Completed							24a. Was an	24b. Were	autopsy findings available to completion of cause of
_		Com							perform	ed? death	1?
Vital	rysician: Th	Be	25. Was case referred to medical examiner?	ospital:			Othor		heck only one		
o		n: To	1 ☐ Yes 2 No	T	28b. Time of	28c. 1	njury at			nce 6 Other (S w injury occurred	pecify)
Sion	auth. or: After he funera	atio	1 Natural 5 Pending investigation	(Month, Day real)	Injury		Mork? I∐Yes 2∐N	10			
Division of	or Attendate deat	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, offi	СӨ	28f.	Location (Str. City or Town,		Rural Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying Phys	ician: To the best of my know	ledge, death	occurred at the	e time, date and	place, and	due to the ca	use(s) and manner	as stated.
	in 24 h	edical	(Check only 2 Medical Examir one)	er: On the basis of examination and manner stated.	on and/or in	vestigation, in m	ny opinion, death	h occurred a	at the time, da	te and place, and o	due to the cause(s)
	To with	Σ	29b. Signature and title of certifier	M.D.			ense number		29	d. Date signed (Mo	
			30. Name and address of person who co		23a) (Tune		00621	1/2		10/11/2	005
H	1.1		SHARAD R SATYAL	, M.D 1604 M/	ARKET	ST	POLOMOI	KE L	ITY M	D 2185	7)
•	Sta		31. Date filed (Month Day, Year) CC 1 2 20	32 degistrar's Signatu	K 1						
	Regist	al		July 1							

DHMH 17 Rev 1/2001

-		1 - For Stete Registrar	State of Ma	aryland		irtment of H tificate of I		lental Hygid Reg	2°005	34476
Physi /Med		Decedent's Name (First, Midd Richard	lle, Last)		Blasey	7		2. Date of Death Month October	7 ^{Day} 2005	3. Time of Death 11:45A. M
Exam		4a. Facility Name (If not institution Holy Cross Ho					Location of Death Spring	-	4c. County of De Montgo	
Funera Directo		5. Social Security Number 577–10–9192	6. Sex 7. Ag	e (In yrs. la 87	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) June 29, 1	9. B 918 Ma	irthplace (State or Foreign Country) Iryland
pu 🔉		Usual Residence of Decedent 10a. State 10b. Count	,	100 City	Town or Loc	4:				
Aanyle I sho	5	Maryland Monto	jomery			Spring				10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
or 28a-1	Direct	10e. Street and Number 3204 Kilkenny				10f. Zip Code	0.4	100	g. Citizen of What C	Country?
leath v ns 23e	era	11. Marital Status	12. Was Decedent	Ever in U.S	13 V	209		ecify You or No.	United	
parmit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Evantral must be notified at	by Fun	1 Never Married 2 X Mail 3 Widowed 4 Divorce	ried Armed Forces? 1 ☐ Yes 2 ☐ Yes Give		It	Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
72 ho	eted	15. Deceder (Specify only higher	nt's Education est grade completed)		16a. Deced	ent's Usual Occupa	ation during most of work	ina 16	b. Kind of Busines	s/Industry
d within giana.	Jamo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Instal	OO NOT use retired)	_	&P Teleph	one Company
d ba file	o Be (17. Father's Name (First, Middle Michael A. Bla	•				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
2 shoul and Ma is mark	۲	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Street a	und Number or Run	al Route Number. (City or Town, State,	Zip Code)
1 and 2 Haalth am 27 ither tra		Marie G. Blase	ey -wile	20b. Pla	_	Kilkenny			ring, Md.	
Pagas ment of ant: If It ury or o	L	1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (3	3 □Removal from State Specify)	Cel	metery, crem	atory or other plac	a)		c. Location - City o	pring, Md.
parmit. Daparti		21. Signature of Funeral Service	Licensee	velt		Harad Voderes	Bofgwardt	Funeral	Home, PA	
200		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complication, that caused	the death.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arres	,	Approximate Interval Between
Physiciar /Medica	_	Immediate Cause (Final disease or condition resulting in death)		e Int	racere	bral Hemo				Onset and Death
Examine		Sequentially list conditions,	Coagulo	opath	У					
cuted nd ransit	Examiner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events	Due to jor as	a dominioning	inea oty:					
ificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):					
in to	fedical		0.							
The law requires that the death certifule has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	leath 3 🗍	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ras that the da signed by the a ba datached	by Ph	Part II. Other significant conditi	ons contributing to death be	ut not result	ing in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
w raquira been signatura should b								1 ☐ Yes	2 X No 3□P	robably 4 🗍 Unknown
	Completed							24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of s
siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital			3□ DOA Othe		(Check only one)		
Phys arthis	7: To	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of Injul	y 2	R/Outpatient 8b. Time of	3 DOM	4 U Nursing Ho	me 5 Residence 28d. Describe how	e 6 Other (Spe	ecify)
ath. r: After	atlor	1 Natural 5 Pendii 2 Accident invest	ng (Month, Da)	i Year)	Injury	28c. Injury Work	? 'es 2 □ No		injury occurred	
Hospital or Attending Physician: 24 hours after death. Funaral Diractor: After this certificially filled in by the funeral director.	Certification:	3 Suicide 6 Could 4 Homicide determ		ury - At hom c. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
To the Hospital or Attendin, within 24 hours after death. To the Funaral Diractor: After complataly filled in by the fun	edical (29a. Certifier (Check only one) Certifying Certifying Certifying Certifying	ng Physician: To the best of Examiner: On the basis of and manner sta	examination	edge, death n and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
To th To th	Ž	29b. Signature and title of certifie	& Das			29c. License	number 2	١	Date signed (Mont	
12		30. Name and address person Steven Schwart	who completed cause of de	eath (Item 2	3a) (Type, P	(rint)	-			
S Regis	tate trar	31. Date filed (Month, Day, Year OCT 11		ar's Signatu	(° Apa	W Avenue	s, wood ne	rearificou,	Masrylar	и 208 9 5

Amend It. 5, Per FH. CCHD. 10 State of Maryfand / Department of Health and Mental Hygiene 0.5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** LILLIAN MILDRED BUELL OCTOBER 7, 2005 4:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HEALTHCARE & FUTURECARE CHERRYWOOD REHAB. CENTER REISTERSTOWN BALTIMORE Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Sociality Alymbor 218 30 - 41 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2X F 1933 MARÝLAND Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercines must be notified at 1 ☐ Yes 2 No Director CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2129 BETHEL ROAD 21048 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 Is marked other th any Injury or other treasment HOMEMAKING 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY WILLIAM GIESLER MILDRED RUTH BOTTOM ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES M. BUELL - HUSBAND 2129 BETHEL RD. FINKSBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 10 Pate 1 / 05 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLLTON CHURCH OF GOD CEM FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME M01191 91 WILLIS ST. WESTMINSTER, 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Muser Examiner Examine the attending physiclen end ched for use as the bunel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 2 Z No 1 Yes 2 No 1 J Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation s efter death. 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only 2 ☐ Madica 29b. Signature and title of of 29c. License number 29d. Date signed (Month. Dav. Year) MA 3 30. Name and addre completed cause of death (Item 23a) (Type, Print) Hett leman (Seene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State blown It Spark Registrar

DHMH 16 Rav 6/95

			1 - For State Registrar	State of Maryl		artment of H			2005	34478
	\$ J. \$		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medic		Raymond James Char	ndler, Sr.				10	Day 7 Year OS	1430 pm
	Examin	M. Kon	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th
15.75H		14	FEDINSULA LEGIONA 5. Social Security Number 6. Sex	Medical	enter	If Under 1 Year	Shury If Under 24 Hrs.	a Day of Bird	Wicon	Pico
	Funeral Director			M 2 F	yrs. last birthday) 86 ^{Yrs.}	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1	rear) C	thplace (State or Foreign ountry)
2	*		Usual Residence of Decedent		00			June 4,	1919	VA
	ylanc	. [10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits
	e Ma	ctor	MD Wicomico)	Salisbur	-y				1X Yes 2 □ No
	ith th or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23a		908 East Rd.	0.144	-110 401	21802		7 7	U.S.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other than *natural; or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at Ques.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 XYes 2 No lif Yes, Give Year or Dates: 7		was Decedent of F f Yes, specify Cub 1 ☐ Yes 2 🖾 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecny Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
ğ	2 hou	ted	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occup		10	Sb. Kind of Business	/Industry
218	thin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	during most of work d)			
21	ed wi	Completed		1		F	Barber		Self Emplo	oyed
lnd	tal H d oth	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	,	
Z∃a	nould I Men narke	ပ္	Gilbert Chandler	Drive)	405-14-70			le Hender		7. 0. ()
Mai	d 2 st th and 7 le n traun		19a. Informant's Name/Relationship (Type Raymond James Char	*		_	2034 , Sal		City or Town, State,	Zip Code)
	1 and Healt em 2		20a. Method of Disposition		b Place of Dione	cition (Name of	1	Data 0	Oc. Location - City or	Town, State
Baltimore,	ages ant of tt: If if		1 ☐Burial 2 ☐ Cremation 3 ☐Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	St. Pau	natory or other pla L's Metho	odist 10/1	5/2005	Berlin	, MD
Ħ	artme		21. Signature of Funer (Spacing)	10	Chilen	Name and Addre	ess of Facility			
å	Depa Impo Impo		100		ŧ.	Lewis N.	. Watson E st Rd. Sa	uneral H	ome MD 21801	
		Ľ.	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the c	death. Do not enti					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		enni	Carlin	en no 4	h		Onset and Death
**	/Medical		resulting in death)	Due to (or as a cor	sequence of):	2.240	myspot	7		
	Examiner		Sequentially list conditions, b	Due to (or a con	ten sic	M				Year
11-0	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a con		_	s helli			Years
	xecut and II-tran	хап	that initiated events cresulting in death) Last	Due to (or con		r enere.	s mea,	tus		70215
8760,	icate be executed physician and s the burial-transit	dlcal E		- 20						
89	ificate g phy as the	edlo	7777777							3 - 1 - 1 - 2
Вох	death certific e attending pl ed for use as t	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of pre		Ectopic pregnanc	.,		23d. Date of de	livery
	the att	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time 9☐Unknown		Other (specify)	у		Month	Day Year
P.0	by tac	Phy	9 Unknown					00. 0	1	
Records,	law requires the as been signed 2 should be de	by	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying cause giv	ven in Parti.	1 ☐ Yes		o the cause of death? robably 4 Unknown
ecc	e law r has be ge 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	Thate ate	S						performe	death?	1
Vital	ystcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	agaital:				h Check only one		
	Phys this al dii	2	1 Yes 2 No		2 ER/Outpatien	I 3LI DOA			ce 6 ☐Other (Spe	ocify)
Division of	ding l h. After funer	lo Ig	1 ☐ atural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wo	rk? Yes 2 □ No	28d. Describe how	injury occurred	
isi	Attending r death. actor: After	flca	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, str		1.00 2	28f. Location (Stre	et and Number or R	ural Route Number.
Ö	after after Directory	Certification:	4 Homicide determined	building, etc. (Sp	pecify)			City or Town,		
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Medical C	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	ician: To the best of my er: On the basis of exar and manner stated.						s stated. e to the cause(s)
	To the I within 2 To the I	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)
	62		1 temando	J. Cule	, ms	00	041211		10/7/0	
	22		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)			1 / / / C	- 3
_	10,7		Fernando Acle 1	00 E. Car.	1011 St	. Salis	buly n	10 218	0/	
200	Sta		31. Date filed (Month, Day, Year) OCT 1 2 2	32. Registrar's S	ignature	1 . w .	se number OYIZII			
100	Registr	ar	COLTNE	Malux.	, Si. Kg	Day				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O E

			For State Registrar	- Clate of Ma	Cei	tificate of	Death	F	Reg. No.) 5 J	14413
П	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month OCt.	1 ^D ay	2Ŏ 0 5	3. Time of Death
	/Medie	cal	Linwood Davis Cor 4a. Facility Name (If not institution, give			Ab Ciby Town o	r Location of Death	oet.		LUUD	01:46A M
	Examir	ier	610 N. Mulberry S	Street		Hagerst	own		Was	shingto	
	Funeral Director		219-30-2934	ox 7.Age	(In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/22/19), _{Year)} 940	9. Birthpl Coun	ace (State or Foreign try) VA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10	Od. Inside City Limits
	Mary e-f ehe	tor	MD Washingt	con	Hagers	town					1 ¥ Yes 2 □ No
	h with the 23a or 28 181 be no	al Dire	10e. Street and Number 610 N. Mulberry S	Street		10f. Zip Code 21740			10g. Citizen o US	of What Coun	try?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 le marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Exameratmust he notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Mas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☒ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		lace - America lack, White, e city: Whi	etc.
2-0	72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	lent's Usual Occup kind of work done	ation during most of worki	ing	16b. Kind of	Business/Ind	ustry
121	within ane. then "	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)			1)		Ç1	neetmet	- 21
2	filed withi Hygiene. other then ent, the M		12 17. Father's Name (First, Middle, Last)	-	1 30	urneyman	18. Mother's Name	(First, Middle,			-aı
an	should be fand Mental I	To Be	Jennings Bryan Co	onstable			Nina Dal	le Davis	3		•
Maryland 21215-0036	and 2 shou ealth and M n 27 le mar er traumat	_	19a. Informant's Name/Relationship (7 Myra M. Constable	* * * * * * * * * * * * * * * * * * * *			and Number or Rura				
	ss 1 and 2 of Health I item 27 r other tr	1 3	20a. Method of Disposition	Domewal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	:e)	Date	20c. Locatio	n - City or To	wn, State
Ë	nit. Pages partment of l cortent: If its injury or o		1 ∑Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specify	9/2005							
Baltimore,	permit. Pages 1 a Department of Hec Importent: If item any injury or othe		21. Signature of Funeral Service Licen	erald N. eet, Hag			neral Home 21740				
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last								Interval Between Onset and Death
68760,	rificate be executed ng physician and as the burial-transit	Medical E	L	d	· · · · · · · · · · · · · · · · · · ·	-					
.O. Box 6	ath cer attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				Date of deliver Month I	y Day Year
<u>α</u>	ires that the de signed by the a l be detached i	by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ontribute to the	e cause of death?
ord	w require been sig		Chrone C	1 programs	tue U	ung		1 🗗 🔨	es 2 No	3 🗌 Proba	ıbly 4 □Unknown
Vital Records,		Completed	<u>cl</u>	seil		~		24a. Was a autops perform	med?	prior to com death?	sy findings available inpletion of cause of
/ita	sician: The certificate harector, page	Be (25. Was case referred to medical examiner?	Manaitab		l Out	26. Place of Death	(Check only	(e)		
of \	d is	7.	1 Yes 2 No 27. Mann of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of		4 LI Nursing Hor	me 5 eside 28d. Describe ho		ther (Specify))
	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	/ear) Injury	28c. Injun Worl M 1 🗆	Yes 2 □ No	ESG. Describe in	544 IIIJuly OCC	ulled	
Division	l or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined		y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Nur n, State)	mber or Rural	Route Number,
_	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 2 Medical Exam	vsician: To the best of liner: On the basis of e and manner state	xamination and/or inv	occurred at the tin restigation, in my of	ne, date and place, a pinion, death occurre	and due to the co	ause(s) and r late and place	manner as sta e, and due to	ited. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	, / 1	m	29c. License	number	2	9d. Date sign	ned (Month, D	Pay, Year)
5H	1-5		30/Name and address of person who	completed cause of dea	in (Item 23a) (Type, I	Print)	veluel	Conn	1001	211	intel 30
	Sta Registi		31. Date filed (Month Pay, Year), 2	32. Fegistrar	s Signature	ek	1	10001	:Ctow	n h	V 21747
				1.5				1			

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of Health tificate of Death	and Mental Hygie	2°005	34480
			Decedent's Name (First, Middle, Last	it)			2. Date of Death		3. Time of Death A
	Physici /Medic		Mary Evelyn C	oak Lev			Month det.	9 2005	12:01 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location	of Death	4c. County of Dea	th
			Washington Coun' 5. Social Security Number 6. Se		. last birthday)	Hagersto	W n r 24 Hrs. 8. Date of Birth		ington
	Funeral Director			I M 2 ME	1 Yrs.	Months Days Hours	Min. (Month, Day, Y	'ear) Co	thplace (State or Foreign ountry) † Virginia
	ס		Usual Residence of Decedent				уерт. 10, 1	914 NC3	virginia
	anylan show	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation			10d. Inside City Limits 1 XYes 2 No
	Be-f	Director	Maryland Washi	ngton	Wil	liamsport	1.0		
	with t		10e. Street and Number	-		10f. Zip Code	109	. Citizen of What Co	,
	death	Funeral	14 North Artiza	12. Was Decedent Ever in t	J.S. 13. \	21795 Was Decedent of Hispanic O	rigin? (Specify Yes or No-	USA 14. Race - Ame	erican Indian,
39	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show dical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cuban, Mexica I □ Yes 2 XX No <i>Specify</i>		Black, Whit	white
21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occupation kind of work done during mo	st of working	b. Kind of Business	
21	S . E	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)			
121	filled with Hygiene. other the		17. Father's Name (First, Middle, Last)			Clerk	er's Name (First, Middle, Ma	ry Cleani	ng
anc	ntal hed of	Be		011				iden Sumame)	
Maryland	shoute nd Me mark matte	ပ္	David Washington 19a. Informant's Name/Relationship (1)		19b. Mailin	g Address (Street and Numb	<u>Mae Hutt</u> Per o <i>r Rur</i> al Route Number, O	City or Town, State,	Zip Code)
	Pages 1 and 2 should be filed vent of Health and Menta! Hygie tent: if Item 27 Is marked other! lury or other treumatic event, Item		Carolyn Spinney -	Daughter			St. Williams	•	
Baltimore,	ss 1 a of Hea		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place)		c. Location - City or	
Ē	permit. Page Department of Importent: If any Injury or once.		XXBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		n Mem. Park O	ct.14.2005 Wi	Hiamspor	t,Maryland
3alt	permit. Departr Importe any Inji		21. Signature of Funeral Service Licent	6000		borne runera		Average Maria estado	21795
_	<u></u>		lay de	Xu_	42	5 S. Conococh	eague St.Will	iamsport,	
I,			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	ith. Do not enti	er the mode of dying, such as	s cardiac or respiratory arrest	'	Approximate Interval Between Onset and Death
	Priysician / /Medical		disease or condition resulting in death)	a disseminat	ich dat	in Mascular	congulation		8 hrs
Ē.	Examiner		- 1	Due to (or as a conse	quence or):		9		
L	100	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	b. Due to (or as a conse	quence of):				
	icate be executed physician and s the burial-transit	Examin	Cause (Disease or injury that initiated events	C					
90,	e exe cian a urial-	Ex	resulting in death) Last	Due to (or as a conse	quence of):				
68760,	cate b	dlcal		d					
-		-	IF FEMALE:	23c. If yes, outcome of pregn	ancy			23d. Date of del	iven
Вох	The law requires that the death certifute has been signed by the attending rage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pregnancy Other (specify)		Month	Day Year
Ö.	that the de led by the a detached t	hys	9 Unknown	9 Unknown				<u> </u>	
S, P	es tha igned be del	ру Р	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause given in Part	I. 23e. Did tobad	co use contribute to	the cause of death?
ord	w requir been si should	ted	what sibrillation	, responence	no he	pertlasin	1 Yes	2 No 3 □ Pr	obably 4 Unknown
Records,	e law r has be	Completed	Osleoporous				24a. Was an autopsy	prior to	topsy findings available completion of cause of
E H			wrinary tract	in fection			performe	d? death? ZNo 1 ☐ Yes	2□ No
Vital	Attending Physicien: r death. r death. ecter this certifical by the funeral director, p	o Be	25. Was case referred to medical examiner?	Hospital:	150/0 hadia	Other	e of Death (Check only one)		
of	Phys or this aral di	H 4	1 ☐ Yes 2 🔂 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c, Injury at Work?	ursing Home 5 Residence 28d. Describe how		cify)
Division	Atending F death. ctor: After y the funer	Certification	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 Yes 2	No		
ivis	r Attender death	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
۵	itel or irs afte rel Dire								
	To the Hospitel or Attenwithin 24 hours after deating the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time, date a restigation, in my opinion, de	nd place, and due to the caus ath occurred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and mainer stated.		29c. License number	29d.	. Date signed (Monti	h, Day, Year)
	F S F O		Krup			DEFI	95	October 0	1,2005
	,		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)			.,.
51	1-3		Dr Bui	138 Opal	Court	Horg. Mc	1 21740		
	Sta		31. Date filed (Month, Day, Year) OCT 1 3 2	32. Registrar's Sign	ature				
	Registr	ar	001 102	-000 Parler	1. A	perker			

State of Maryland / Department of Health and Mental Hygie 1 1 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Vaa **Physician** GAY CORNETT OUT 9120 PM LINDA 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year)
Jan. 28, 1948 Maryland If Under 1 Year | ff Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛣 F 215-52-9194 57 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Gaithersburg Marvland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 20878 USA or items 23a 421 West Side Drive, #104 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or itemeny injury or other traumers. 1 Never Married 2 Married White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Education Budget Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray H. Cornett Juanita Peterson 2 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13317 Dauphine Street, Silver Spring, MD 20906 Ray H. Cornett/ Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 2005 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc Kichard Z Males 500 University Blva, w, Silver Spring, MD 20901 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final 6 MOS Physician METASTATUC COLOREOTAL CANGER resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transli and Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical use as the IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 No 1 Yes 2 No Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 2 **X**No 1 Impatient 2 ER/Outpatient 1 🗌 Yes 3 DOA Medical Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely To the 29d. Date signed (Month, Day, Year) 29c. License number D0061083 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 10 CENTER DR. # 300, ROCKVILLE, MD LHAMBI 1801CAL State 2005 marke

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H		Mental Hy	/giene) Reg. No.	05 3	34482
	Division		1. Decedent's Name (First, Middle, Las	1)				2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		JOSEPH WILLIA	AM CO	X		_	OCTOBI	ER 8	2005	8:35 P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		h		County of Death	
			275 BARSTOW ROAD			BARSTOV				LVERT	
	Funeral		5. Social Security Number 6. Se	ox 7. Ag DXM 2□F	ge (In yrs. last birthday) 88 Yrs.	Months Days	If Under 24 Hrs Hours Min	8. Date of B (Month, D APRIL	irth Pay Year)	9. Birthp	
	Director		578-05-2246 Usual Residence of Decedent		00			APKIL	23,19	1/ MAK	YLAND
	fand ow		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary -1 sh	ţ	MD CALVERT		BARSTOW						1 ☐ Yes 2 No
	7 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	itry?
	h with	D E	275 BARSTOW ROAD			20610			U.	S. A.	
	deati	Funeral Director	11. Marital Status	12. Was Decedent Amped Forces	Ever in U.S. 13.	Was Decedent of H	spanic Origin? (S	ipecify Yes or N	0- 14	Race - Americ Black, White,	
9	or Its	/Fu	1 Never Married 2 Married	1.XQXYes 2 □	No	1 ☐ Yes 2 / ☐ (No	Specify:	to riloun, oto.,	S	enecify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Madical Examiner must be notified at	d by	3XWidowed 4 ☐ Divorced	Year or Dates:	'44-'46	7111				WH	ITE
5-("natu	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occup kind of work done of DD NDT use retired	during most of wo	rking	16b. Kind	d of Business/Inc	dustry
121	withir sne. than	du	Elementary/Secondary (0-12)	College (1-4or	5+) PLUMB		,		PLUM	BING	
	Hygie ther int, II		17. Father's Name (First, Middle, Last)	_	1 Horris	DK	18. Mother's Na	me (First, Middle	1		
an	d be antal ced o	o Be	JOSEPH KELLY COX				EDNA E	LISE OWE	ENS		
Maryland	shoul nd Me mark mark	F	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Numi	ber, City or 1	Town, State, Zip	Code)
<u> </u>	nd 2 ulth a 27 is r trau		ELIZABETH A. COX	/ DAUGHTI	ER 275 B	ARSTOW RI	P.O.B	X 103 E	BARSTO	WN. MD	20610
ē,	s 1 a f Hei itam othe		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	e) OCTO	DBER	20c. Loca	ation - City or To	wn, State
Ë	Page nent c int: If		1 ☐ Burial 2XX remation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		BRINSFIEL			2005	CHAR	LOTTE H	ALL, MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, It a Modical Examiner must be notified at once.		21. Signature of Funeral Service Licens	- A-96	22	2. Name and Addres	s of FacilityBR	INSFIELI	-ЕСНО	LS FUNL	.HME.,P.A.
œ	8 8 E 8		ferm 18	80	M00641 30	195 THREE	NOTCH I	RD. CHAF	RLOTTE	HALL,	MD 20622
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each I	d the death. Do not entine.	er the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Me	tastation	Pros	tate	Cance	~		Yews
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	73,000					1
	LAdillilei	_	Sequentially list conditions, if any, leading to immediate	b. — Due to (or or	a consequence of):						
	ed sit	ine	fr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence or):						
	xecut and Il-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):	· · · · · · · · · · · · · · · · · · ·					
8760,	icate be executed physicien and s the burial-transit	dicai E		a i							
687	ficate physics the	a a		9.							
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		1=			23	d. Date of delive	ry
Ď.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a		Ectopic pregnancy Other (specify)				Month	Day Year
0	that the death certific ed by the attending p detached for use as	Physician/M	9 Unknown	9□ Unknown							
s, P.	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	ру Р	Part II. Other significant conditions co	entributing to death t	out not resulting in the u	nderlying cause give	en in Part I.				e cause of death?
rd	w require been signal	pel						1 🗆	Yes 2 🗆	No 3 ☐ Prob	ably 4 Munknown
Records,	law re as be 2 she	Completed						24a. Was		24b. Were autop	osy findings available inpletion of cause of
<u> </u>		Con						perf	ormed?	death? 1 ☐ Yes	2 🗌 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?					ath (Check only	one)		
of \	> 0) TI	P	Tes ZIXINO	Hospital: 1 Inpati			4 Nursing r			Other (Specify	')
n		lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury Year) 28b. Time o	Work	rat ⟨? Yes 2 □ No	28d. Describe	now injury o	occurred	
Sic	Attending r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	300 Plans of In	jury - At home, farm, str		162 2 140	28f Location	(Street and I	Number or Rura	I Poute Number
Division	or A efter Dirac	Certification:	4 Homicide determined	building, e	tc. (Specify)	eer, racidry, office			wn, State)	various or rigia.	Tiodia Hamber,
	spital ours naral filled		29a, Certifier 1 Certifying Phy	/sician: To the best	of my knowledge, deat	h occurred at the tim	ne, date and place	and due to the	cause(s) ar	nd manner as st	ated.
	To the Hospital or Attent within 24 hours efter deatl To the Funaral Director: completely filled in by the	edical			of examination and/or in						
	To th within To th comp	Me	29b. Signature and title of certifier	0 1		29c. License	number		29d. Date s	signed (Month, I	Day, Year)
			1 mation	Le		D5	9061		ОСТОВІ	ER 10, 2	2005
			30. Name and address of person who d	ompleted cause of	death (Item 23a) (Type,	Print)					
M	P 10+1		Dr. A. Patel,	Prince Fr	ederick, M)					
	Sta		31. Date filed (Month, Day, Year)	32. Reast	rar's Signature						
	Registr	ar		THE REAL PROPERTY.	WW SS A	10846					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per doc 8848 10-25-05 vt.

		•	For State Registrar		State of Ma	ıryland?	•	ment of 1- ficate of		d Men		giene Reg. No.	005	3448	33
	Physicia		1. Decedent's Name	(First, Middle, Last)							Date of De Month	ath Day	Year	3. Time of I	
	/Medic	al .	dith	not institution, give	C and another			h City Tours o	r Location of De		epteml		30,2005 County of Dea		m M
	Examin	er								Saur			ontgome		
	Funeral Director		11208 JOS 5. Social Security No 77–40–923	10		e (In yrs. last	birthday)	f Under 1 Year fonths Days	If Under 24 H	in. (Date of Bird (Month, Da	th y, Year)	9. Bi	thplace (State or ountry) ifornia	r Foreign
7	2	1	Usual Residence of		703	10c City T	own or Locat	ion						10d. Inside Cit	v Limits
1	shov ed at	5		Montgomer	37			.011						1 Tes	
	or 28a-1 show	Director	10e. Street and Nun		У	Kensi	ngton	10f. Zip Code				10g. Citiz	zen of What C	ountry?	
	3a or		3112 Fav	vette Road				20895				US	Δ		
	еше з	Funeral	11. Marital Status	TO ROOM	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Wa	s Decedent of H es, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify lerto Rica	Yes or No an, etc.)	-	4. Race - Am Black, Wh	erican Indian, te, etc.	
900	permit. Pages 1 and 2 should be liled within 72 hours arier uean with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or theme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	þ	1 Never Marrie 3 Widowed	ied 212 Married 4 Divorced	1 ☐ Yes 2 🙀 N If Yes, Give Year or Dates:	lo	1	Yes 28 No					Specify: W]	nite	
ה ה	natu	Completed	(Spec	15. Decedent's Educify only highest grad		1	6a. Deceden	t's Usual Occup of of work done	pation during most of v d)	working		16b. Kir	nd of Business	/Industry	
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י כ	Hygie Hygie ont,		17. Father's Name ((First, Middle, Last)			ice P	residen	t of Bai 18. Mother's N		rst, Middle,		king Sumame)		
2	Aental Aental rkad c	To Be	William	Frederick	Robert M	ilks			Sophia	a Ba:	iley	Walt	ers		
<u>a</u>	and N			ame/Relationship (T)		1		,	and Number or						
∑ .``	and sealth m 27 her tra			Wolcott-	Daughter				Drive I	Rock			ryLand		
	or ot			Cremation 3 □F				on (Name of lory or other pla	1						
altimor	ortant g	'		5 Other (Specify)		Fort		In Crema lame and Addre						Marylan al Home	
מ ם	Department of the partment of			12 44	en (x) è				kville E	_					
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F	hysician		Immediate Cause (disease or conditio	(Final	. /_1	VCC	Fai	lure						Onset and D	Death
ı	/Medical Examiner		resulting in death)		Due to (or as	a consequen	ce of):	-15							
H	D #	lner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	nditions, nmediate erlying	b. Due to (or as	a contequen	ce of):	1 -					**		
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XOD .	ath ce attendi	Physician/M	23b. Was decedent	it pregnant	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3 □E	ctopic pregnanc	у			2	23d. Date of de Month		'ear
	the de	yslc	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9 Unknown	ume or dead	300	ittiei (specily) _							
ري ح	law requires that the death certil as been signed by the attending 2 should be detached for use a	by Pf		ficent conditions co		ut not resultin	ng in the unde	erlying cause giv	ven in Part I.		23e. Did t	obacco u	se contribute	to the cause of de	eath?
	equire en sig ould b		con	19esti	ve He	art	-a	11016		_	1 🗆 '	Yes 28	3 3 □ F	robably 4 🗆 U	Inknown
Vital Records,	sician: The law re s certificate has be lirector, page 2 shr	Completed								-		psy rmed?	prior to death?		available ause of
<u>a</u>	in: The	e Co	25. Was case refer	rred to medical					26. Place of (Death (C	1 Yes		1 ☐ Ye	s 24 No	
=	ysicie is cert direct	OB	examiner? 1 ☐ Yes 2		Hospital: 1 🗌 Inpatie	ent 2 ER	/Outpatient	3 DOA Ott					Other (Sp.	hone	hter's
n or	ng Ph fter th	on: T	27. Manner of Deat	th 5 Pending	28a. Date of Inju (Month, Da	ry 28 y Year)	b. Time of Injury	28c. Inju Wo	rk?	28d.	. Describe	how injur	y occurred	HORE	
20	tendi Jeath tor: A the fu	catl	2 Accident	investigation 6 Could not be	One Place of Ini	At home	form almo		Yes 2 No	28f	Location (Street and	d Number or 6	Rural Route Numi	her
DIVISION	alor At s after o il Direc d in by	Certification	4 Homicide	determined	28e. Place of Inj building, et	c. (Specify)	s, tarm, stree	t, ractory, onice		201.	City or To	wn, State,)	iarai nodie nomi	Der,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying Phy ☐ Medical Exem	rsicien: To the best iner: On the basis o and manner st	of my knowle f examination ated.	dge, death o and/or inves	ccurred at the ti stigation, in my	me, date and pla opinion, death o	ace, and ccurred a	due to the at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s))
	To th within To th compl	Me	29b. Signature and	I title of certifier					se number			29d. Dat	e signed (Mor	ith, Day, Year)	
			1/0	VV				40	0543	37		9	130	200	5
0			-	ress of person who c	ompleted cause of o	leath (Item 23	Ba) (Type, Pr	int)	arting	GAT	0 (+1	1) and	hunn	11 2176	a 7
	Sta	to	31. Date filed (Mon	nth, Day, Year)	e anacc	ar's Signatur	54	ال مد	mi iirig	une	- 01 0	~ 000	cumen	14 01/	1 /
	Regist				2005 Ang	ואג המ	GOL	and I							

			1 - For State Registrar	State of M	laryland	d / Depa	artmen rtificate	t of He	ealth a	and Me	ental Hy	Reg. N		3 14 14	
П	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month	Da	ay Year	3. Time o	
	/Medic		Lottie Dixon				4. 6.	-			ctobe		2005 c. County of Dea	5:55	<u>Р</u> м
	Examin	er	4a. Facility Name (If not institution, garantees Cresent Cities		r)			ivero	Location o 1a1e	n Death			PRINCE		3
	Funeral				kge (In yrs. Ia	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	B. Date of Bi	rth	9. Bir	thplace (State	or Foreign
	Funeral Director		578-24-8028		83	Yrs.	Months	Days	Hours	Min.	B. Date of Bi (Month, D. larch	15°1	922 Ash	ville N	1C
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or La	cation							10d. Inside (Dity Limits
	Aaryta f sho	ō	MD Prince G	eorge!s	Hyat	tsvil:	1 _e							1 🙀 Yes	s 2□No
	r 28a-	Funeral Director	10e. Street and Number		Tryac	COVII	10f. Zip						itizen of What C		
	23a c	ai D	5104 North Engle	wood				785					ted Sta		
	r dea	nei	11. Marital Status	12. Was Deceder Armed Forces	5?	5. 13.	Was Deced If Yes, spec	lent of His	spanic Orig n, Mexican	gin? (Spec , Puerto R	ify Yes or Nican, etc.)	0-	14. Race - Ame Black, Whi	te, etc.	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 24☐ If Yes, Give Year or Dates			1 ☐ Yes	2∰ No	Specify:				Specify,Bla	ck	
9	2 hou atura	ted	15. Decedent's	Education		16a. Dece	dent's Usua	I Occupa	tion	t of workin	•	16b.	Kind of Business	/Industry	
215	thin 7	Completed by	(Specify only highest g	College (1-40	r 5+)		kind of woi DO NDT us		uring most	OF WORKING	9	D			
21	ygjen ygjen her th	Co				Beau	ticia		19 Matho	r'a Namo	(First, Middle	1	ivate		
Maryland 21215-0036	d be findal H	Be	17. Father's Name (First, Middle, Las Benjamin Crump						Char			imor			
Ž	should ad Me mark matic	은	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	nd Numbe	er or Rural	Route Numb	er, City	or Town, State,	Zip Code)	
	nd 2 state and 2 s		Lillian Williams/			23 Ma	adiso	a St	NW W	ashir	gton	DC 2	20011		
5	s 1 ar		20a. Method of Disposition		1 00	ace of Dispo emetery, crei	sition (Nan	ne of ther place	,)	Da			Location - City or	Town, State	
E	Page nent o int: If		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec			mony (1	10-11	-2005	La	indover	Md	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any highry or other traumatic event, the Medical Evantment must be routified at ODEs.		e of Funeral Service Lic	Below	sio						Funer.		Iome OC 20020		
3760,	ate be executed why sician and hysician and the burial-transit	licai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a conseque a conseque	ence of):	Can	ren	пои	rati	ish i	78	Breast-	Approxima Interval Be Onset and	Death
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3[⊒Ectopic pr ⊒ Other (sp						23d. Date of de Month	blivery Day	Year
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Re	: The law cate has t	Jmo:	Bra	in me	tas	اعع					auto perf 1 Tyes	opsy ormed? 2 ∑ ∕N	death?	completion of s 2 □ No	cause or
ita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						110010		(Check only				
of V	8 v =	၉	1 ☐ Yes 2 X No	Hospital: 1 Inpa		ER/Outpatier		-	4 DO NU	-			6 □Other (Spe	ecify)	
uc)	te te	ion:	27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Ir (Month, I	Day Year)	28b. Time o Injury	M	8c. Injury Work 1 □ Y	al ? ′es 2⊟I		ou. Describe	HOW IN	ury occurred		
Division of Vital	or Attending F ifter death, Director: After in by the funer	Certification:	2 Accident INVESTIGAT 3 Suicide 6 Could not 4 Homicide determine	be 28e, Place of	Injury - At ho etc. (Specify	me, farm, st					8f. Location City or To		and Number or R	iural Route Nu	mber,
Δ	To the Hospitel or Attendi within 24 hours after death, To the Funeral Director: A completely filled in by the fo		29a. Certifier TS Certifying (Check only 2 Medical Ex	Physician: To the be aminer: On the basis	st of my know	wledge, deat	h occurred	at the tim	e, date an	d place, a	nd due to the	cause(s) and manner a	s stated.	(e)
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 20		strar's Signat		de								

DHMH 17 Rev 1/2001

		1 - For Prt.l. State Registrar Amend #23a.							and M		eg. No.	05	34485
Physicia	n	1. Decedent's Name (First, Middle, L.		1		D				2. Date of Dea Month	Day	Year	3. Time of Death
/Medic	al	Elizabeth 4a. Facility Name (If not institution, gi	Hayo			Drury	Town or	Location of	of Death	October 5	1	ounty of Deat	6:50 A M
Examin	er			91)		_ ′	kville					itgomery	
Funeral Director		Shady Grove Adventis 5. Social Security Number 6. 577-03-4292	st Hospital Sex 7. 1□ M 2xxxx	Age (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 23,	1916	l Co	nplace (State or Foreignitry) ington, DC
B 3		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation	_						10d. Inside City Limits
Maryla faho	0	Maryland Prince Ge	eorge's		emple Hi								1 □ Yes 🛠 📈 No
7.28a-	rect	10e. Street and Number			1	10f. Zip	Code			1	l 0g. Citize	n of What Co	untry?
23a o	alD	3300 25th Avenue					748				USA		
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Hygid Hygid Sther ent, II	Ö	12 17. Father's Name (First, Middle, Las	st)							e (First, Middle,	Maiden S	umame)	
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2 should and N		19a. Informant's Name/Relationship				•				ral Route Numbe			Zip Code)
and and and and and and and and and and		Mary Hannan / Daught	cer	205	-			e Rock		e, Maryland Date		350 ation - City or	Town State
pes 1 i of 뇬 if iter or oth		20a. Method of Disposition 1xxBurial 2 ☐ Cremation 3	☐Removal from St	212	Place of Disponentery, cressurrecti	matory or c	other plac	e)		8, 2005		on, Mar	
thent tant: tant:		4 ☐ Donation 5 ☐ Other (Spec	city)	ines		O Nama ar	ad Addros	e of Eagli	ib.				
permit Depar Impor any in phoe		21. Signatury Funeral Strvice Lice	2				Oxon	Hi11	Geo Road	orge P. Ka Oxon Hill		neral H land 2	
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Examiner			Pro	PIRA	TOR	1 5	AIL	1101	EAK	T FAIL	UKE		IWEEK
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	ras a consec	quence of):								
Ite be executed lysicien and he burial-transit	cal Exa	resulting in death) Last	Due to (o	r as a consec	quence of):								
death certificat e attending phy id for use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregn		□Ectopic p					23	d. Date of de	
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juires that n signed b	þ	Part II. Other significant conditions	contributing to dea	th but not re	sulting in the	underlying o	cause giv	en in Part	l.	23e. Did to		,	the cause of death? robably 4 DUnknov
The law requires that the sate has been signed by the page 2 should be detached.	Completed											24b. Were as prior to death?	utopsy lindings availab completion of cause o
	Be C	25. Was case referred to medical		- 11				26. Plac	e of Dea	1 ☐ Yes th <i>Check only</i> o	1	10.100	2010
ysici is cer direci	To B	examiner?	Hospital: 1	patient 2	ER/Outpatie	ent 3 D	OA Oth	er: 4 🗆 N	ursing H	ome 5 Resid	lence 6	Other (Spe	icify)
ng Ph Iter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month	Injury Day Year)	28b. Time Injury		28c. Injur Wor			28d. Describe h	now injury	occurred	
Attending Physician: or death. ector: After this certific by the funeral director,	Certification:	Accident investigat 3 Suicide 6 Could no	be 28e Place o	ol Injury - At I	home, larm, s	treet, lactor		Yes 2]No	28f. Location (S City or Tow		Number or R	ural Route Number,
al or	Sert	4 Homicide	buildin	g, etc. (Spec	ary)					Only or row	m, State)		
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying (Check only one) 1 Certifying 2 Medical Ex	Physician: To the laminer: On the base	sis of examin	nowledge, dea nation and/or i	nvestigation	at the tir	me, date a pinion, de	nd place ath occu	, and due to the orred at the time,	cause(s) a date and p	nd manner a	s stated. e to the cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier				29	c. Licens	e number					th, Day, Year)
		PMadu	anim	0		1	000	631	29		OCT	OBER	5,2005
(6)		30. Name and address of person will Powlimi Nadkarni	no completed cause MD 9901		em 23a) (Type l Center	Print)				land 2089	50		
Sta	ate rar	31. Date liled (Month, Day, Year) OCT 1 20	OS . Re	gistrar's Sign	nature								

DHMH 17 Rev 1/2001

Director

99	요 문 #			
.O. Box 6	The law requires that the death certifica Ite has been signed by the attending ph oage 2 should be detached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
<u>α</u>	w requires that been signed by should be deta	Partin Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 140 3 Probably 4 Unkno
Division of Vital Records,	sicien: The law certificate has b irector, page 2 sl			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
<u> </u>	triffic ctor.	25. Was case referred to medical examiner?		Death (Check only one)
2	ysio	1 Yes 2 146	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Wursin	g Home 5 ☐ Residence 6 ☐ Other (Specify)
ion o			28a. Date of Injury (Month, Day Year) ation 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
Divis	s after de si Directo si Directo	27. Manney of Death 1 Natural 2 Accident investige 3 Suicide 6 Could no determin	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ns Hospit n 24 hour ne Funer pletely fill	29a. Certifier 1 Certifying (Check only 2 Medicel E	Physician: To the best of my knowledge, death occurred at the time, date and pl ixeminer: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	
_	omp of	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	03	MH	02/1	11/2/18
	To a	30. Name and address of person w	who completed cause of death (Item 23a) (Type, Print)	
	18	WILLIAM ROBINS,	M.D. 200 CIVIC AVE., SALISBURY, MD.	21804
	Stat	31. Date filed (Month, Day, Year)	32. Registrar's Signature	
	Registra	r OCT 1 2	2 2005 Steams & Sparte	
Dł	HMH 17 Rev 1/20	01	-	
			ORIGINAL.	

Due to (or as a consequence of):

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Bernice Mary Elizabeth Dale October 7,2005 6:40A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SALISBURY MD 21804

Trunder 1 Year Vir Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign SALISBURY REHAB & NURSING CENTER
5 Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 🛛 F 95 Yrs. Sept. 6, VA 213-22-8559 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Salisbury 1 XYes 2 No Wicomico Director MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S. 21804 1220 E. Middleneck Dr. Apt. E by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐MNo Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Housekeeping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annie Sturgis John Edward Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1220 E. Middleneck Dr. Apt. E, Salisbury, MD 21804 Alice Mack/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Acres
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/11/2005 Salisbury, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lewis N. Watson Funeral Home 1618 West Rd. Salisbury, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 11 Due to (or as a conseque nce of) 625 horase 4100 Due to (or as a consequence of): Examiner

/Medical **Examiner**

cal

e burial-tran ysician and

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 → HO 3 Probably 4 Unknown

		•	For State Registrar	State of Ma	ryland		artment <i>tificate</i>					giene	4 3 5 3 1	5	34487	
	-		Registrar 1. Decedent's Name (First, Middle,	Last)		001	imoaic	, 0, 2			2. Date of De	ath			3. Time of Death	
П	Physici /Medic		Mack	John			D	avis	5		Month	- (Year	20120	M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, 7	Town, or	Location of	of Death			. County o	f Death		
			The Johns Hop	runs Hospi	tell				If Under	Cit	4					
П	Funeral		5. Social Security Number 214–48–7630	. Sex 7. Age 15☑M 2☐F		ast birthday) 56 Yrs.	If Under Months	Days	Hours	Min.	Oct.11	y, Year 10/	18 1	9. Birthi Coul	place (State or Foreigntry)	gn •
	Director		Usual Residence of Decedent								000.11		ŧ0 V	vasii	Ingcon, DC	_
	ryland		10a. State 10b. County Maryland Prince	Cooresta		Town or Lo									10d. Inside City Limit	
	8e-f.	cto		George S	Gree	enbelt						10 0			1 XYes 2 □ N	
	filed within 72 hours after death with the Maryland Hygiene. ther then "neturelt, or Items 23a or 28e-f show ant, the Mydical Examinet must be notified at	Funeral Director	10e. Street and Number 126 Northway Roa	d			10f. Zip	207	70				itizen of WI Lted S			
	ems 2	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	6. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	-		- Ameri	can Indian, etc.	
36	s after	by Fu	1 ☐ Never Married 2 ☐XMarrie 3 ☐ Widowed 4 ☐ Divorced		lo		1□ Yes 2		Specify:				Specify:		hite	
号	2 hou	ted t	15. Decedent's	Education		16a. Dece	dent's Usua	Occupa	ation			16b. h	Cind of Bus	iness/In	dustry	
215	thin 7: en "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	+)	life.	kind of wor DO NDT us	e retired,	iuring mos)	it of work	ing					
7	ygieni ygieni ier th	Con	Elementary/Secondary (0-12)	5	+	Attor	ney		40.14.4		(F) 1 14:14		gal_	,		
and	d be fil ental H ked oth c even	a)	17. Father's Name (First, Middle, L. Herman Bernard D					ŀ	Franc		e (First, Middle,		n sumame 11sky)		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel; or Items 23a or 28e-1 show amorphism of the recommend of the Maryland Examinet must be notified at any intry or other treumatic event, the Maryland Examinet must be notified at ange.	-	19a, Informant's Name/Relationshi Constance M. Da	o (Type, Print) Vis-wife		19b. Mailir 126	ng Address North	(Street a	and Numbe Road	er or Rura	al Route Numbe	er, City Mar	or Town, S	itate, Zij	770	
	1 and Health Iem 27		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nam	e of			Date		ocation - C			
ē	Pages ment of l		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Contro		Met	metery, crer	natory or ot itan (ner piaci Crem	atory	7 10/	7/2005	Ale	xandr	ia,	Virginia	
Baltimore,	permit. Page Department Importent: If any injury or otice.		21. Signature of Funeral Service Li	censee	1	B	onaid 1000 D	d Address	BoFgv	vardt	Funera	al H	lome,	PA		
	00360		23a. Part1. Enter the disease, or o	omplications that caused	the death								lle,	Mar	yland20705 Approximate	5_
			shock, or heart failure. List o	nly one cause on each lin	10.		or the mode	, o. o,	9, 000		,				Interval Between Onset and Death	
	Physician /Medical	ļ	disease or condition resulting in death) a. Evol Struce Liver Disease Due to (or as a consequence of):											lyear		
Н	Examiner			Commi			SHP	Oct	itis						luear	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):	7190	1-00	111						J	
	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	2 0000000	ianco of):										_
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687	ficate physis the		0.7	d												
Box	n certi	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth			DEctopic pro	nananav.					23d. Date			
O. W	es that the death certificingned by the attending p	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (spe			-			Mont	th	Day Year	
<u>Р</u>	hat the d by t letach	Phy	9 ☐ Unknown Part II. Other significant condition		ut not resi	Itting in the II	nderlying ca	use dive	an in Part I		23e. Did t	obacco	use contril	bute to t	he cause of death?	
Records,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	d by	Pattil. Otto Significant condition	o continuating to dodd to	ut 110 t 100 t			adda giri			10	Yes 2	2 28 No 3	3 🗆 Pro	bably 4 Unknow	vn
20	w requires been si	Completed									24a. Was		24b. W	ere auto	opsy findings availab)le
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ita	ien: rrifica ctor, p	Bec	25. Was case referred to medical examiner?						26. Place	e of Deat	h (Check only			•		
<u>×</u>	Physicien: r this certifica ral director, I	70	1 ☐ Yes 2 ☑ No	Hospital: 1 Mnpatie		ER/Outpatier			4 🗀 140		me 5 Resi				fy)	
Division of Vital		Certification:	27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Inju (Month, Day	ry y Year)	28b. Time o Injury	f 2	8c. Injury Work	/at k? Yes 2 □		28d. Describe	how inji	ury occurre	d		
ISI	f or Attending after death. Director: After I in by the fune	ficat	2 Accident investigation of Could not determine	t be 28e. Place of Inju	ury - At ho	me, farm, st								r or Rur	al Route Number,	
<u>S</u>	Dir	erti	4 Homicide	building, et	c. (Specify	<i>'</i>)					City or To	wn, Stai	te)			
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		290	. License	e number			29d. D	ate signed	(Month,	Day, Year)	
	-		Calharine C	amphell,	Medic	ed Doc	FOR	Res	-000			oct	rober	6.2	2005	
1.	5		30. Name and address of person v	ho completed cause of d	eath (Item	23а) (Туре,	Print)									
1			Catherine Ca	mpbell, Th	e Joh	ins Hor	otcins	HOSP	Inti	600 N	wolfe	St,	Baldin	Sylve	MD 21205	5
	Sta Regist	ate rar	OCT 11	2005	ui a oigila	ture H. A	me									
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			For State Registrar	State of N	Maryland		artment rtificate				1ental H	ygie Reg.	$Z \cup U$	15	3448	38
			1. Decedent's Name (First, Middle, L	ast)							2. Date of I			was a	3. Time of 0	Death
	Physici		Stephen	Edwa	rd			Dev	nnis	on	Month	er	Day	Year 2.005	1057	Ам
1	/Medic Examin		4a. Fecility Name (If not institution, g.	ive street and numbe	or)		4b. City,	Town, or	Location	of Death			4c. County	of Death		
	- Addition		Johns Hopkins Ba	uview Meo	tical a	enter	Bal-	tim	ore							
	Funeral				Age (In yrs. la		If Under		If Under		8. Date of E	Birth		9. Birth	place (State or	Foreign
	Director		213-54-8599	N⁄⊋M 2□F	55	Yrs.	Months	Days	Hours	Min.	Aug.			Wash	ington,	
	D		Usuel Residence of Decedent	•												
	how	_	10a. State 10b. County		10c. City	, Town or Lo	ocation								10d. Inside City	
	e Ma	cto	Maryland Mont	gomery	N	Montgo	mery	Vill	age						1 🗆 Yes	ZKINO
	er 28	Director	10e. Street and Number				10f. Zip	Code				10g.	Citizen of	What Cou	ntry?	
	23a	a	19425 Brassie Pla	ace, Apt.	103			0886					τ	JSA		
	and and and and and and and and and and	Funeral	11. Marital Status	12. Was Deceder Armed Force	s?	3. 13.	Was Deced	ent of Hi	ispanic Ori n, Mexicai	igin? (Sp n, Puerto	ecify Yes or I Rican, etc.)	No-		ce - Americk, White,	can Indian, etc.	
90	or II	Y.F.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2x		i	1 ☐ Yes 2		Specify:				Specifi	y. Whi	± 0	
21215-0036	ural LEX	d by	3 Widowed 4 XDivorced	Year or Dates	S:							1				
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12	withir than		Elementary/Secondary (0-12)	College (1-40	or 5+)		esman	e reureu,	,			١,	Furnit	ure	Retail	
2	filed within 72 hours after deeth with the Maryland Hygiene. Wher than "natural", or Itame 23a or 28a-f ahow wit, the Medical Examiner must be motified at	ပိ	17. Father's Name (First, Middle, Las			Dui	Coman		18. Mothe	er's Nam	e (First, Midd					
an(od o	(CO)	Ernest E. Dennis								F. Mi			,		
Ē	d Me d Me mark	ို	19a. Informant's Name/Relationship			10h Mailir	an Address	(Street a			ai Route Nun			State 7in	Code	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23s or 28s-f ahow eny injury or other traumatic event, the Medical Examiner must be notified at other.		Stephen J. Denni								ensing					
نه			20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nam	e of	20 0040	-	Date	200	. Location -	City or To	own, State	
Baltimore,			1 Burial 2 □ Cremation 3		(0	of Hea	-			Octo		LO		•		
틀	ntan night	1	 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 		dace						005				ng,Mary	land
Ba	Depart Depart Import eny in		AnneMa	reflerk	er						Funeral, W,				, MD 20	0901
.8			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that caus y one cause on each	ed the death line.	. Do not ent	er the mode	of dying	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Betw	
	Physician		Immediate Cause (Final disease or condition	Cardi	ac Ar	rest									Onset and De	ath
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9	n certific anding pl use as t	Med	IF FEMALE:								737A - 17			1		(10.2
Вох	ith ce itendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1□Live birth		death 3	Ectopic pre							te of delive	,	ar
<u>.</u>	the al	Sici	1 Yes 2 No	4□Pregnant 9□Unknown		ath 5	Other (spe	ecify)					1910	лип	Day 16	ROLI
P.O.	that the death certif ed by the attending detached for use as	Phy			b 4 4	late and all					20- 0	4 4 - 1		16 4 - 4 - 41		
	8 E 8	Completed by Physician/Me	Part II. Other significant conditions	_	i Dut not rasu	iting in the u	ngenying ca	iuse give	in in Part I	•	T		2 No		ne cause of de nably 4 ⊟Ur	
oro	w requir been si should	ted	Esophageal Can	er							1	Yes	2 & NO	3 [] F100	abiy 4 _br	KIIUWII
e C	has b	ple									24a. Wt	oosv	24b.	Were auto	psy findings av	railable use of
<u> </u>	The ate h	Con									per 1 ☐ Yes	formed 2 1	13/	death? 1 🔲 Yes	2 No	
ita Ta	ertific octor.	Be	25. Was case referred to medical examiner?							of Deat	h (Check only	one)				
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Division of Vital Records,	l or Att after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not determine		Injury - At hor etc. (Specify,	me, farm, str)	eet, factory,	, office			28f. Location City or T			er or Rura	d Route Numb	er,
	urs al						III. C. M. Start				2. (11.91.91)					
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	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	uno manner	Janou.		29c.	License	number			29d.	Date signe	d (Month,	Day, Year)	
•	->-0	100	Duney					RES	-000			Do	tober	- 6	2005	
			30. Name and address of person wh	o completed cause o	f death (Item	23a) (Tyne		2.7						01	5-0,5	
1	0			astern Aver		Baltin		MD	212	24						
Ė	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signat	ure	-									
	Registr		OCT 11	2005	strar's Signat	y. A	184EL									

			For State Registrar		State of Ma	aryland / De <i>C</i>	•	nent of Ho cate of D		lental Hy	/gien Reg. N		34489		
	0,			ne (First, Middle, La	ist)					2. Date of De	eath	ay Year	3. Time of Death		
	Physicia /Medic		Ra	alph	Duvall			<u>-</u> <u>-</u>		Oct.	6		12:05 P		
	Examin				e street and number)				Location of Death		4	c. County of Deat	h		
					Nursing H			Westmi Under 1 Year	nster If Under 24 Hrs.	0.0	Carroll				
L	Funeral Director		5. Social Security N 220-28 Usual Residence of	-8112	Sex 7. Ag	e (In yrs. last birtho	Moi	nths Days	Hours Min.	8. Date of Bi (Month, Di Aug.	ay, Year		hplace (State or Foreign nuntry) MD		
	land		10a. State	10b. County		10c. City, Town o	or Location	n					10d. Inside City Limits		
	Many Ff sh	tor	MD	Carr	coll	We	stmir	nster					1 ☐ Yes 2√2 No		
	or 284	Director	10e. Street and Nu	mber			10	f. Zip Code			10g. C	itizen of What Co	untry?		
	23a c	ral	2636 B	irdview	Road			211.				United States			
	tems	26.36 B1rdV1eW ROad 21157 Uni 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 M Married 1 19 19 19 19 19 19 19										 Race - American Indian, Black, White, etc. 			
	72 hours after death with the Maryland neturel', or Items 23s or 28s-f show dical Examinet must be multised at	þ	1 Never Man	ried 2 Married 4 Divorced	1 Yes 2 Yes If Yes, Give Year or Dates:	No	1□Y	es 2⊠ No	Specify:			Specify: W	Mhite		
)	, 72 hours "neturel", Jical Ex.	etec	(Spe	15. Decedent's E cify only highest gr	ducation ade completed)	(0	Give kind	Usual Occupa of work done di OT use retired)	urina most of work	ing	16b.	Kind of Business/	Industry		
1		Completed	Elementary/Sec	ondary (0-12)	College (1-4or	5+)		Constru				self-e	mployed		
2	filed Hygi other ent, I	0	8th 17. Father's Name	(First, Middle, Las	t)				18. Mother's Name	First, Middle	e, Maide				
3	itd be lental rked c	To B	H	arrv Ravm	ond Duvall				j	Julia K	athe	erine Bal	ker		
2	s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other then other treumatic event, II:a M	} —		lame/Relationship			Mailing Ad	dress (Street a	nd Number or Rura	al Route Numb	ber, City	or Town, State, 2	Zip Code)		
) IA	and 2 ealth a m 27 ls		Nellie	Marie Du	ıvall wif			Birdvie		Vestmin	·		1157		
5	00		20a. Method of Dis 1 ☑ Burial 2		☐Removal from State	20b. Place of D cemetery,	oremator)	(Name of y or other place		Date	20c. I	Location - City or	Town, State		
	Pages tment of t tent: If ite		° 4 □Donation	5 Other (Speci	ify)	Taylors	vill	e Cemet	ery Oct.	10, 20	05	Taylorsv	ille, MD		
	permit. Pag Department Importent: I eny injury o		21. Signature of F	uneral Service Life Mu4	Cam	1	Buri	ne and Address	^{s of Facility} 121 een Funer	al Hom	old I e &	Liberty I Cremator	Road 21784 ry, PA		
	Physician		23a. Part1. Enter shock or her Immediate Cause disease or conditi- resulting in death)	art failure. List only (Final	nplications that cause y one cause on each li a. Mul	ishler	Con		g, such as cardiac o				Approximate Interval Between Onset and Death		
	/Medical Examiner			- 1	Due to (or as	a consequence of):						<i>J</i>		
	uted d ansit	Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event	mmediate lertying r injury	Due to (or as	a consequence of)):								
Ś	ficate be executed physician and is the burial-transit		resulting in death)	Last	Due to (or as	a consequence of):								
	ficate p phys	edical			d										
.C. DO	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		pic pregnancy er (specify)				23d. Date of del Month	ivery Day Year		
į,	that	by Pr	Part II. Other sign	ificant conditions	contributing to death t	out not resulting in t	he underly	ing cause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?		
3	w requires been sig should be									1 🗆	Yes :	2 (No 3□Pr	obably 4 Unknown		
	rsicion: The law requ s certificate has been lirector, page 2 should	Completed								24a. Was auto perfi 1 Yes		24b. Were au prior to death?	itopsy findings available completion of cause of		
	len: rtifica stor, p	ø	25. Was case refe	erred to medical					26. Place of Deat	1	_				
>	Physic this ce al direc	To B	examiner?	No	Hospital: 1 Inpati			□ DOA Othe	4 Nursing Ho		-	6 ☐Other (Spe	cify)		
=	Attending Physicien: The sr death. ector: After this certificate he by the funeral director, page	on:	27. Manner of Dea	ath 5 ☐ Pending	28a. Date of Inju	y Year) 28b. Tin	ury	28c. Injury Work	:?	28d. Describe	how inj	ury occurred			
2	tend death tor: /	Icatl	2 Accident	investigation 6 Could not i	he -	ium. At homo form	N street 4		fes 2□No	28f Location	(Street	and Number or P	ural Route Number,		
2	rs after el Direc	Certification:	4 🗌 Homicide	determined	building, e	jury - At home, fam ic. <i>(Specify)</i>	1, 3(166), 1	actory, office		City or To			nar riodio riamber,		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely illed in by the funeral director,	edical	29a. Certifier (Check only one)		thysician: To the best miner: On the basis of and manner st	f examination and/									
	To 1 To 1	M	29b. Signature and	d title of certifier	mill.	4		29c. License	number 447		29d. D	Pate signed (Monta	h, Day, Year)		
	W 4 X 4		30. Name and add	dress of person who	completed cause of	1 00	ype, Print	$I \cap I$	Wist	nin (ter	MD	21157		
•	Sta Registr		31. Date filed (Mo	onth, Day, Year)		rar's Signature	1			11-1-1		1			
		471-		UULU	LUUJ J	MAN ST	M								

State of Maryland / Department of Health and Mental Hygiere 0 0 5 36490 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Bernard Joseph Freed October 6, 2005 7:45 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Bowie 12224 Foxhill Lane 8. Date of Birth (Month, Day, Year) Mar. 20,1922 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 10XM 2□ F Yrs. Director 83 035-16-8974 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show The Medical Exercitive must be notified at 1X Yes 2 □ No Bowie Director Prince Georges Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** "netural", or Itams 23e 20715 12224 Foxhill Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) iit. Pages 1 and 2 should be filed within runent of Health and Mental Hygiene. rtant: If itam 27 is marked other than "injury or othar traumatic avant, Ital Me College (1-4or 5+) Elementary/Secondary (0-12) Auditor - US Treasury US Gov't. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anne K. Cafferty Frank J. Freed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12224 Foxhill Lane, Bowie, Maryland 20715 Dorothy Freed - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 10-10-05 Clinton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) permit.
Deportr
Importa
any inj 21. Signature of Funeral Service Liv 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events ding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medlcal use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be DIECTOMO 1 Yes 2 → No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1 Yes 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P this 28a. Date of Injum (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 Yes investigation hours after death. 2 Accident within 24 hours after deatl To tha Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 105 40037228mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cafferty, MD, 225 Townsquare Dr., Lusby, Maryland 20657 Stephen P. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2005 OCT Registrar

			1- State of Maryland / I		rtment of I tificate of		nd Men		20 C)5	34491	
	Physici		1. Decedent's Name (First, Middle, Last) Joseph Earl Fry			•	l A	oate of Death Month October	Day	Year 2005	3. Time of Death 11:30P. M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, o	_		000001	4c. Coun	nty of Death		
	Funeral Director		5. Social Security Number 6. Sex 196–14–8847 7. Age (In yrs. last bit	irthday)_ Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. D	Date of Birth Month, Day,	Year)	9. Birth	place (State or Foreign ntry)	
	ס		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Loc	ation		Ju	ly10,1	925		Sylvania 10d. Inside City Limits	
	he Mary 28a-1 sh	Director	Maryland Prince George's Gree	enbel				40	077		1 ☐ Yes 2 ☐ No	
	3a or 3		108 Julian Court		10f. Zip Code	0770		10		of What Cou nited	States	
30	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, I've Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼Divorced 12. Was Decedent Ever in U.S. Armed Forces? ↑□ Yes 2 □ No If Yes, Give Year or Dates: WWII		as Decedent of P Yes, specify Cub	n? (Specify ' Puerto Ricar	Yes or No- n, etc.)					
21215-0036	72 hour 'natural			a. Decede	ent's Usual Occup	during most of	f working	10	6b, Kind of	p. Kind of Business/Industry		
717	d within giene. er than '	Completed	Elementary/Secondary (0·12) College (1·4or 5+) 2 S		o NOT use retire intender	,			Const	ructi	on	
land	uid be file Aental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last) George Fry			18. Mother's Virgin		st, Middle, Ma ay Upd		ame)		
Mary	nd 2 should be th and Mental 27 Is marked of traumatic ev				Address (Street							
ore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Ia marked any injury or other traumatic evonce.		20a. Method of Disposition 20b. Place o	n - City or T								
Saitimor	ermit. P. epartme nportant ny injury		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22	Namo and Addre	es of Encility						
	403 e d		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter	00 Powder the mode of dying	er Mill ng, such as car	Road rdiac or res	Belts	ville	, Mary	y Land 20705 Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lunc Due to (or as a consequence		ncer						Onset and Death 6months	
L,	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of).								
΄,	certificate be executed dding physician and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	of):						-		
00/8c	icate be physicia s the bur	edicai	d.									
C. Box	certi nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		ectopic pregnancy Other (specify)	y				Pate of delive Month	ery Day Year	
ds, r.	requires that the death een signed by the atter hould be detached for u	by	Part II. Other significant conditions contributing to death but not resulting in congestive heart failure; acute re				2		cco use cor		he cause of death?	
Lec	8 C	Completed					_	24a. Was an autopsy performe		were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of	
VIII AII	Physiclan: this certific ral director.	Be	25. Was case referred to medical examiner? Hospital: Hospital:		3/7 DOA O#	26. Place of		ack only one)				
Io uoi	Phy this ral d	ation: To	27. Manner of Death 28a. Date of Injury 28b.	Time of Injury	28c. Injur	v at	28d. [5 🗌 Residen Describe how			(y)	
DIVISION	al or Atte s after des Il Directo id in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stree	et, factory, office			ocation (Stre City or Town,		nber or Rura	al Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death o	occurred at the tirestigation, in my c	me, date and pl ppinion, death o	place, and di occurred at	ue to the cau the time, date	se(s) and me and place	nanner as s , and due to	tated. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of Certifier		29c. Licens D240					ed (Month,		
1	2		30. Name and address of person who completed cause of death (Item 23a) Mark Parkhurst, M.D. 5711 Sarvis A	(Type, Pr	rint)	dole :		- 1 00=				
	Sta Registr		31. Date filed (Month, Day, Year) OCT 11 2005 32. degistrar's Signature	Jon Jon	e River	uale, M	uaryla	na 207	3/			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year James Duttera Le Ferre 9 6:27 AM /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of Maryland Medical Cente University Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) PA **Funeral** 1**⊋**M 2□ F Director 215-03-3537 1913 LITTLESTOWN, 92 Sept. Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2√2 No CARROLL WESTMINSTER Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō Items 23a 21158 1219 OLD TANEYTOWN ROAD death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after of Hygiene.
I Hygiene. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Š 1 ☐ Yes 2 TNo Specify: WHITE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR CIRCULATION DEPT. NEWSPAPER 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: If Itam 27 is marked othe any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLAUDE MEHRING LEFEVRE ပ EDNA DUTTERA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY H. LEFEVRE - WIFE 1219 OLD TANEYTOWN RD. WESTMINSTER, MD 2115 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) M MEADOW BRANCH CEM. 10/12/2005 WESTMINSTER, MD 21. Sunature of Funeral Service Licensee 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME 91 WILLIS STREET WESTMINSTER, M01191 MD 21157 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acuta Subdural disease or condition resulting in death) 7 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mittated events CERTIFICATION APPROVED TO PEDICAL EXAMINER Examiner Due to (or as a consequence of) physician and is the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medlcal attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ been sign Subdural 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has b irector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 20KNo the Hospital or Attanding Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After s after dea. 1 Natural 5 Pending 10:45 AM subject slipped on curb 2 Accident 1 Yes 2 No investigation oct 2, 2005 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Bond St & Park Place within 24 hours aft To tha Funaral Di completely filled in Stret 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) AU4176435616535 oct. 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Baltimore. 22 S. Greene Street Felix Lui, mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Rag. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 8:20AM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Homewood at Crumland Farms Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. 27, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 72 215-36-7238 Mary land Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other than "natural", or items 23s or 28e-f show treumatic event, the Madical Examinations to profitted at 1 ☐ Yes 2 ☐ No Directo Maryland Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7407 Willow Rd. 21702 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by White 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) farmer dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental I Allen L. Flanigan Evelyn Cashour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret J. Klemme/daughter 2761 Muddy Creek Lane Coralville, IA 52241 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ö Utica Cemetery 10/7/2005 Utica, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Foneral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine burial-transi Due to (or as a consequence of): 68760 attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) _ ed by the a Ö 9 Unknown 9 Unknown page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 □Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nown to physican autopsy 1 Yes 2.X No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 0 1 🗌 Yes 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Alatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined or A 4 - Homicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

			For State Registrar	S	State of	Marylan	d / Depa	artment of F	lealth a <i>Death</i>	and Me		iene g. No.	05 3	4494
			1. Decedent's Name (First,	Middle, Last)						2	Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		JEAN	ELAY	NE		GOLI	BERG		0	ctober	10	2005	6:49 A ^M
	Examin	er	4a. Facility Name (If not ins	titution, give stre	et and numb	ber)		4b. City, Town, o	r Location o	of Death		4c. Cc	ounty of Death	
			11710 Old Ge					Rockv If Under 1 Year		24 Hrs. In	2		Montgo	
	Funeral		5. Social Security Number	6. Sex 1 □ N	20 X F	. Age (In yrs. 94	last birthday) Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day	Year)		ace (State or Foreign try)
	Director		091-05-7390 Usual Residence of Deced	ent		74				S	ept 13	1911	New	York, NY
	yland		10a. State 10b. C	ounty		10c. Cit	y, Town or Lo	cation					10	Od. Inside City Limits
	Mar B-f sl	tor	MD Mor	ntgomery		Ro	ckvill	_e						1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number					10f. Zip Code			1		n of What Coun	•
	23a	ral	11710 Old (Georgeto	wn Roa	ad #110)5E		20852			Unit	ed Stat	es
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural', or iteme 23a or 28e-f show any highty or other treumatic event, the Medical Eracinal Item Colling and ODGs.	/ Funeral	11. Marital Status 1 Never Married 2	Married	Was Deced Amed Force 1 Tes 2 If Yes, Give	No Set No		Was Decedent of H fYes, specify Cuba 1□Yes 2☑No	lispanic Origin, Mexican Specity:	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)		Race - America Black, White, e becify:	etc.
21215-0036	ural'.	d by	3 ☑ Widowed 4 □ Div		Year or Dat	θ S :							W	hite
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0	Hygo other ent,	Be C	17. Father's Name (First, N	liddle, Last)			1101	ICMARCI.	18. Mothe	r's Name (F	First, Middle,			
<u>la</u>	fental fental rked ric ev	To B	Nathan Smit	:h					A	nna Be	erman			
ary	shou s man		19a. Informant's Name/Re	ationship (Type	Print)			g Address (Street						/
Σ	and 2 alth a n 27 i		Norman Goldh	erg, Sc	n				eorge	town l	Rd #13:	20W R	ockvill	e MD 20852
Baltimore, Maryland	of He		20a. Method of Disposition 1√2 Burial 2 ☐ Crem	ation 3∏Ren	oval from St		Place of Dispo emetery, crer	sition (Name of natory or other plac	(9)	Date	9	20c. Locat	tion - City or To	wn, State
Ĕ	Pag ment ent: i		'4 □Donation 5 □ Ot		10441 110111 31		ng Davi	d Mem Gr	dns	10-11-	-2005	Fa11	s Churc	h, VA
3alt	Depart Import any inj		21. Signature of Funeral S	ervice Licensee		0.0								Home, Inc.
	0.05 4 0		Cla	1	one	W.		.800 New					Spring	
			23a. Part1. Enter the diseashock, or heart failure	List only one	cause on eac	used the deat ch line.	n. Do not ent	er the mode of dyin	g, such as	cardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a				metastat	ic to	liver	unkno	wn p	rimary	
н	/Medical Examiner		100011119 111 000011,			r as a conseq	uence of):							
		-	Sequentially list conditions	, b	ASHD Due to Jor	r as a consell	uence of							
	ned nosit	nin	cause. Enter Underlying Cause (Disease or injury	· ~		l fibr		on						
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C.		r as a conseq		OII						
8760,	icate be executed physician and s the burial-transit	dicai		d.	Diabe	tes								
9	tifical ng phy as th	0 1												
XO	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregna	arit		ome of pregna th 2 Peta		Ectopic pregnancy	,			23d	. Date of deliver	
B	ne dea the att	sici	in the past 12 months 1 ☐ Yes 2 ☑ No	7	4☐Pregnar	nt at time of d		Other (specify)					Month !	Day Year
P.O.	that the de ed by the detached	Phy	9 Unknown Part II. Other significant co	anditions	buting to doe	th hout not soo	ulting in the	-db-i	an in Dad I		22a Didad			a cause of death?
ds,	es De	d by					uniting in the u	idenying cause givi	on in raiti.			naccouse ns 2 Da N		ably 4 □Unknown
Records,	w requir been si should	Completed	Congest	ive Hea	rt rai	lure					-			
3ec	has has l	шpі									24a. Was a autops perforr	V	prior to com death?	sy findings available pletion of cause of
a			05 11/2								1 Yes	X No	1 ☐ Yes	2□ No
Viital	Physician: r this certific ral director,	o Be	25. Was case referred to n examiner? 1 ☐ Yes 2X No		pital: 1 □ Ing	nationt 2	ER/Outpatier	t 3 DOA Oth	or		heck only on		Other (Specify)	
of	Phys er this eral di	\vdash	27. Manner of Death		28a. Date of (Month,		28b. Time of	28c. Injun	y at		I. Describe ho			
ion	Attending F r death. ector: After by the funer	atio		Pending nvestigation	(Month,	, Day Year)	Injury	M 1 🗆	k? Yes 2 🗀 i	No				
Division of	or Attend efter death Director: /	Certification:		Could not be determined	28e. Place o	f Injury - At ho	ome, farm, str	eet, factory, office		28f.	Location (St City or Town	reet and N	lumber or Rural	Route Number,
Ö	s effer el Direce ed in by	Cert			Dallaling	g, 610. (Op00//	<i>''</i>			- //	Oily or Town	, State)		
	To the Hospitel or A within 24 hours efter To the Funerel Direc completely filled in by	Medical	29a. Certifier K Cs (Check only one) 2 Ms	rtifying Physic edical Examine	ian: To the b : On the bas and manne	is of examina	wledge, death tion and/or in	n occurred at the time restigation, in my o	ne, date and pinion, deat	d place, and th occurred	I due to the ca at the time, da	iuse(s) and ate and pla	d manner as sta ace, and due to	ted. the cause(s)
	To the within To the Comp	×	29b. Signature and title of	certifier	20	-		29c. License			1		igned (Month, D	
1			May	las B	Ma	epa	1	6368	DC			Octob	er 10,	2005
_	•		30. Name and address of p	erson who comp	leted cause	of death (Item	1 23a) (Type,	Print)						
10	2		Charles B.	Abrams,	M.D.	1120 1	9th St	reet, NW	Suite	200,	Washi	ngtor	DC 2	20037
	Sta Registi		31. Date filed (Month Day	1 1 200	32.	gistrar's Signa	S. A	mede						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34495 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1810 OCTOBEL Belle 6 2005 /Medical Haughton 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BROOKE GROVE REHABILITATION AND NURSING CENTER SANDY SPRING MONTGOMERY 7. Age (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) | Month | Days | Hours | Min. (Month, Dey, Year) 5. Social Security Number 6. Sex Funeral Birthplace (Stete or Foreign Country) Days 1 □ M 24 □ MF Director 481 16 6188 Nov 13, 1921 Iowa Usual Residence of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes ZZNo Maryland Montgomery Directo Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1639 Hickory Knoll Road 20860 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus filled within 72 hours efter Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 K No Specify: \$ 3 Vidowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filled within Department of Health end Mental Hygiene. Important: If Item 27 is marked other then 'eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Counselor Public Schools 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Garrison Cora Lee Rounds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Haughton / Son 221 Hickory Lane Newton Square, Pennsylvania 19073 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Garden of Memories 10/13/2005 Waterloo, Iowa 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or fleart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . UROSEPSIS WEEK Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and I for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? the ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown DUSPHACHA DIABETES MELLITUS; 2 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? has certificate 1 Tes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ဥ 1 ☐ Yes 2X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours efter ded To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t⊠ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month. Day. Yeer) - ATTENDING PHYSICIAN OCTOBER 08, 2005 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

GLACE BROOKE HUFFMAR, M.D. 18100 SLADE SCHOOL RUAD SANDY SPRING, MARYLAND 20860

32. Registrer's Signature

AFRAGA

Registrar

State

31. Date filed (Month, Day, Year)

OCT 11 2005

		,	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H rtificate of		-	ene 2.00	5 344	96	
	Physic	ian	Decedent's Name (First, Middle,					2. Date of Death Month		Year 3. Time	of Death	
	/Medi	cal	Alvin	Francis	Holz.		1 2 10	October			0 a M	
4	Examir	ner	4a. Facility Name (If not institution, Holy Cross Hos	1	4b. City, Town, or Location of Dea Silver Spring			ath		4c. County of Death		
	Funeral			•	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hi		Montg	Omery 9. Birthplace (State	or Foreian	
	Director		074 18 2983	1 X M 2□ F	82 Yrs.	Months Days	Hours Mi	n. (Month, Day, April 24		New York	or v orongr.	
	P .		Usual Residence of Decedent					inpitit 24	1/43	NEW TOTK		
	arylar show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside		
	8a-f	ecto	Maryland Montgo	mery	Silver						s 2 XNo	
	with th	P.	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Country?		
	s 23	erai	642 Bennington I	12. Was Deceden	Ever in 11 C 12	209		/C===/6_V====N==	USA	A ::e - American Indian,		
10	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examinar must be positied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Forces	?	If Yes, specify Cub	an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Blac	ck, White, etc.		
215-0036	urs al	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify	White		
Õ	2 ho	Completed	15. Decedent's		16a, Dece	dent's Usual Occup	pation	. 11	6b. Kind of Bu	usiness/Industry		
218	within 7 ene. than "r be Med	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	life	kind of work done DO NOT use retire	during most of w d)	orking				
2	filed withi Hygiene. other than	Con		5+		Geologi	st		US Gov	vernment		
nd	should be filed within nd Mental Hygiene. marked other than imatic event, the Mental control of the Mental con	Be	17. Father's Name (First, Middle, La	ıst)			18. Mother's N	ame (First, Middle, M	laiden Suman	ne)		
yla	Men Men Marke Marke	ဥ	Anton Holzle			11	Sophie	Strettmu	tter			
Maryland	2 sho and ls m		19a. Informant's Name/Relationshi			ng Address (Street	and Number or F	Rural Route Number,	City or Town,	State, Zip Code)		
	of Health of Health Item 27 i		Catherine_Holz1	e Carrese/	17505	Jacobs_	Court De	rwood, Ma	ryland	20855		
OL	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 Surial 2 Cremation 3		3 '	matory or other plac				City or Town, State		
ţ	nit. Pa entmen ortant: njury		`4 Donation 5 Other (Spe		Gate of F	leaven Cer	metery 1	0/10/05 S	ilver S	Spring, Ma	ryland	
Baltimore,	permit. Pages 1 Depertment of H Important: If Ite any njury or ot 2069.		21. Signature of Funeral Service (ii	Men Men						neral Home		
			23a. P 11. Enter e disease, or co sho a, a feart failure. List or	st,	Approxima Interval Be	ite itween						
	Physician		Immediate Cause (Final disease or condition	Ischem	ic Colitis					Onset and 4 da	Death	
	/Medical		resulting in death)	Due to (or as	s a consequence of):						, -	
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	ק ק	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequence of):							
	ecute and trans	cam	that initiated events resulting in death) Last	c								
60,	oe ex cian a	E	Toolskii g iii dollat j Llat	Due to (or as	s a consequence of);							
68760,	icate be executed physician and the burial-transit	dicai	دير	d								
_		0	IF FEMALE:	23c. If yes, outcome	of prognancy							
Вох	death certif e attending ed for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy	у		23d. Dat	te of delivery nth Day	Year	
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t time of death 5	Other (specify)				-,		
<u>α</u>	requires that the death een signed by the atte hould be detached for	Ph	Part II. Other significant condition	s contributing to death I	but not resulting in the u	nderlying cause giv	en in Part I	23e. Did toba	acco use contr	ribute to the cause of	death?	
ds,	es pe	d b	End Stage Renal			,				3 ☐ Probably 4 ☐		
Ö	w requir been si should	ete	Aortic Stenosis		7.							
Records,	e la has	Completed						24a. Was an autopsy perform		Were autopsy findings prior to completion of death?	cause of	
a			Atherosclerotic	Heart Disc	ease			1 □ Yes 2	No 1	☐Yes 2☐No		
Vital		Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only one				
of		1; To	1 Yes Start No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpatier ury 28b. Time o	f 28c Injur	v at	Home 5 Residen				
on	ding Ph th. After th funeral	tio	1 Natural 5 Pending 2 Accident investiga	(Month, Da	ay Year) Injury	Wor	rk? Yes 2 ⊡No		ingary coodin			
Division	or Attending after death. Director: After In by the fune	Certification;	3 ☐ Suicide 6 ☐ Could no	be One Olege of In	jury - At home, farm, st			28f. Location (Stre	et and Numbi	er or Rural Route Nur	n <i>ber</i> .	
<u>S</u>	P Sirt e	erti	4 Homicide	building, e	tc. (Specify)	,,,		City or Town,	State)			
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, deat	h occurred at the tin	me, date and place	e, and due to the cau	ise(s) and ma	nner as stated.		
	• Ho 124 P	Medicai	(Check only 2 Medical Ex	aminer: On the basis of and manner s	of examination and/or in	vestigation, in my o	pinion, death occ	curred at the time, dat	e and place, a	and due to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier		011	29c. Licens	se number	29	d. Date signed	(Month, Day, Year)		
			effer	× alla	the m	D47	7188	0	ctober	6, 2005		
1	2+1		30. Name and address of person wi	no completed cause of	death (Item 23a) (Type.	Print)						
			Jeffrey A Port				d Rocky	ille. Marv	1and	20852		
	. Sta	ate	31. Date filed (Month, Day, Year)	32. Regist		_				20032		
	Regist	rar	001 11	2005	15. P.	all!						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Year **Physician** October 3, Mammie Hackney 10:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing and Rehabilitation Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🖫 F 578-30-8433 98 South Carolina Director 11-22-1906 Usuat Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic avent, the Madical Examinar must be notified at 10d. Inside City Limits Montgomery Maryland Takoma Park 1 Yes 2 □ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7620 Maple Avenue 20912 United States death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel many injury or other traumatic avent, the Medical Exert Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: African-1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Elevator Operator Elevator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harris Turner Dinnah McCloud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Albertha Wheeler/Niece 6532 North Capitol Street, Washington, DC, 20a. Method of Disposition

X□ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Rock Creek Cemetery 10-7-2005 Washington, DC ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral and 21. Signature of Funeral Service Licensee Cremation Center, 1040 Rockville Pike, Rockville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Anal Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that but to the cause) Due to (or as a consequence of): Examine rsician and e burial-transit that initiated events Anemia resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical ending physic r use as the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes 2X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred After 5 Pending within 24 hours efter death, To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D4699 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuum Tel MD 3415 Hamltm ST HyAthville MD 2078Z 12 31. Date filed (Month, Day, Year)

OCT 1 0 2005 32 Aegistrar's Signature State Registrar

			For State Registrar	State of N	Maryland / Depa <i>Ce</i>	artment of H rtificate of L	ealth an Death	d Menta	I Hygier		3	445	8 8
F	Dhoolal		1. Decedent's Name (First, Middle, Last,						te of Death	Day Y	'ear	3. Time of	Death
	Physicia /Medic		Mary L. Howar	d						2005 رُ		9:45	РМ
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death 4c. County of Dea							
			Waldorf Healthcar 5. Social Security Number 6. Sec				Waldorf Charles If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 17, 1930 West Vir					-/	
	Funeral Director			M 20X F	Age (In yrs. last birthday) 74 Yrs.	Months Days		Min. 8. Dat	onth, Day Yea	วี จรก พู	Country	i rai	nia nia
			Usual Residence of Decedent					1001	J. 1/9	1330 11	230 1	11911	
	nylan how		10a. State 10b. County		10c. City, Town or Lo	ocation					10d	I. Inside Ci	•
	Ba-f e	Director	Maryland Charles		Bryai	ns Road						1 🗌 Yes	21 No
	vith th	Dire	10e. Street and Number			10f. Zip Code	1.0		10g. (Ditizen of Wh	at Country	17	
	s 23s	erai	2756 Cheyenne Cour	12. Was Decede	na Evroy in U.C. 12	206		2 (64:)/-		USA	A	Indian	
	ter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	6?	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, P	uerto Rican,	etc.)	14. Race - Black,	White, etc		
036	al', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 🔀 No	Specify:			Specify:	W	<i>l</i> hite	
5-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occupa	ation	workina	16b.	Kind of Busi	ness/Indus	stry	
7	ithin Se. han "	mpie	Elementary/Secondary (0-12)	College (1-4d	or 5+)	kind of work done of DO NOT use retired)	g		D -	-1		
2	iled w Hygier Iher ti		12 17. Father's Name (First, Middle, Last)			Realtor	19 Mothor's	Namo /Firet	Middle, Maid		al Es	tate	
Maryland 21215-0036	id be f ental I ked or ic eve	To Be	Dwight L. Hall					arl Jo		en Sumame,			
ary	shou and M s mar	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street a	and Number o	or Rural Route	Number, City	y or Town, St	ate, Zip Ci	ode)	
Σ	and 2 salth an 27 li		Vicki E. Howard - I	Daughter		6 Cheyenn	e Cour	t, Bry	ans Roa	ad, MD	2061	.6	36
ore	of He		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ F	Removal from Sta	20b. Place of Dispo cemetery, creater	osition (Name of matory or other plac	θ)	Date	20c.	Location - Ci	ty or Town	n, State	
altimore,	Page Iment c lant: If jury or		`4 □ Donation 5 □ Other (Specify)		Moser C	rematory		/13/05		renton	-	_	a
Ball	Top Top												VA 86
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or		A _l	pproximatenterval Bet	ween						
	Physician		Immediate Cause (Final disease or condition	Al	31-M'FA	Dist	ME				0	nset and [Death
	/Medical Examiner		resulting in death)	Due to (or	a a consequence of):								
В		er	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequence of):								-
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events		, ,								
oʻ	an andrial-tra	Exa	resulting in death) Last	Due to (or	as a consequence of):								
8760,	cate be executed physician and the burial-transit	dicai		d									
9	entifica ling p	a a	IF FEMALE:										
Вох	death certifi e attending i d for use as	Physician/M	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy				23d. Date of Month			Year
o.	0 60	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		Other (specify)							
<u>α</u>	The law requires that the site has been signed by the bage 2 should be detache	y Ph	Part II. Dther significant conditions co	ntributing to deat	h but not resulting in the u	inderlying cause give	en in Part I.	23	e. Did tobacci	use contrib	ute to the	cause of d	leath?
Records,	quires n sign	ed by	two ERTENS	102				_	1 🗌 Yes	2 □ No 3	Probab	ly 4 🔀	nknown
000	aw requir s been si 2 should I	piet	PARANOLA					24	a. Was an			y findings	
Ä	The lav	Completed							autopsy performed? Yes 2	dea	or to comp ath? Yes 2[itetion of ca □ No	ause or
Vital	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of	Death (Chec					
of V	9 5	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp			4 Cotursii		Residence				
o no	ing Ifter	ertification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury 28b. Time o Day Year) Injury	Worl	r?		escribe how in	jury occurred			
isic	Attending or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of	Injury - At home, farm, st		Yes 2□No		cation (Street	and Number	os Puro I E	Pouto Alum	hos
Division		ertif	4 Homicide determined	building,	etc. (Specify)	reer, ractory, onice			y or Town, Sta		JI MUIAI M	Oute Num.	Der,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	calc	29a. Certifier 1 Certifying Phy	sician: To the be	est of my knowledge, deat s of examination and/or in	h occurred at the tim	ie, date and p	place, and due	to the cause	(s) and mann	er as state	ed.	
	To the H within 24 To the F complete	Medical	uney	and manner	stated.			occurred at th					1)
	To Yell	- Can	29b. Signature and title of certifier	n alr	1	29c. License	H H	136		Date signed (i			
F			20 Name and addition	ompleted saus	of death (Item 22-) (T		1 7	1 3 9	00	Cfo.	07	. 20	200
1	1175		30. Name and address of person who do				rf, MD	20602					
	Sta	ite	21 Date filed (Month Day Veer)	32. Re	Strar's Signature	/ 4	. ,						
	Regist	rar	001114	2005	telus D.	Course							

State of Maryland / Department of Health and Mental Hygiene 0 0 5 34499 1 - State Registral Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** OCTOBER MARY LORETTA HAYTON 2005 3:38 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 26277 JESSIE JANE ST. MARY'S PLACE MECHANICSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 20, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗓 F Months 77 Yrs 148-20-0601 NEW JERSEY Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow or Items 23e or 28a-f ahov golingt roust be notified at 1 XYes 2 □ No Director NJOCEAN TOMS RIVER / DOVER TOWNSHIP 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 24 WILLIAMS DRIVE 08755 S. Α. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Exertiners 1X Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 151-158 Specify: ð 3 X Widowed 4 □ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 CONTRACT SPECIALIST DEPARTMENT OF ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) , Pages 1 and 2 should be fill timent of Health and Mental Hitant: If itam 27 Ia marked oth ANDREW KRAFT SR. CATHERINE DUNLEAVY 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANA M. PRICE / DAUGHTER 26277 JESSIE JANE PLACE MECHANICSVILLE, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State OCTOBER Department of Important: If it is eny injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST.JOSEPH'S CH. CEM. 13, 2005 TOMS RIVER, NEW JERSEY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL. HME., P.A. MO0641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastati Pnysician /Medical **Examiner** Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a nonsequence of): Examiner OPD requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Tes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence XXOther (Specify DAUGHTER Statement of the Nursing Home 1 RESTREAM RESIDENCE. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attanding 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To tha Funaral C

completely filled 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 10-10-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manoj Panwala, Charlotte Hall, MD 20622 32. Registrar's Signature 31. Date filed (Month, OC State 2005 Registrar

			State of Maryland / Department of Health and Me	•	•	
			1 - State State Certificate of Death	Reg	211115	34500
			1. Decedent's Name (First, Middle, Last) •	2. Date of Death		3. Time of Death
	Physici /Medio			OC+	8 2005	- 8:10AM
الجور الر	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deal	h
			5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 1	0.5 (5:4)	<u> </u>	nore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birti	nplace (State or Foreign untry)
	_		Usual Residence of Decedent	ון אוו,אווכ	141	1 71
	arylari show	_	10a. State 10b. County 10c. City, Town or Location Partimore Paged Hall			10d. Inside City Limits 1 Yes 2 □ No
	ha Mi	ecto	10e. Street and Number 101. Zip Code 105.	100	Citizen - 4 Mills - 4 Co	
	with 3a or		2913 Meeting House KD 21128	109	Citizen of What Co	untry ?
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215-0036	within 72 hours aftar death with tha Maryland ana. than "natural", or itame 23a or 28a-f show he Madical Examirer must be notified at	Completed by	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business/I	ndustry.
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and	be filt	Be	17. Father's Name (First, Middle, Last)	- 1	1/.	- 1
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<u>≅</u>	nd 2 shoulth and 27 ie m		MARGARET K. NeiDLINGER 3913 Meeting House	0 /	RYHALL	Valla Alla
Je,	gas 1 and 2 should be filad within 72 hours aftar death with tha Marylan to of Haalth and Mantal Hygiana. It of Haalth and Mantal Hygiana. If Item 27 is marked other than "natural", or Itame 23a or 28a-f show or other traumatic event, the Modical Examinat must be notified at		20a. Method of Disposition 20b. Place of Disposition (Name of Da	-	c. Location - City or 1	
Ĕ	E and Fa		1 ABurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	2005 Le	EDANON.	TA
Baltimore	parmit. Pag Dapartmant Important: i any injury o		21. Signature of Funeral Service Licensee	11	Po Box	155)
	40.260	0 1	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or	Home I	Littleston	Approximate
		Į,	shock, or heart failure. List only one cause on each line.	respiratory arrest,		Interval Between Opset and Death
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89	tificat og phy as th					
Box	th car tandir or usa	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy		23d. Date of delin	very Day Year
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P.O.	that ti	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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000	aw raquir is been si 2 should	plete	Attial pubullation	24a. Was an	24b. Were aut	opsy findings available
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Division	ar das	Certification;	3 Suicide 4 Homicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stree City or Town, S	t and Number or Rur	al Route Number,
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	Mithin To the To the compla	Me		29d.	Date signed (Month,	Day, Year)
	, F °		Chule 5. Andley D12405	7	0/9/05	
	AC.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	40 40	1.1	
			30. Name and address of person who competed cause of death (item 23a) (type, Print) C(+A(LLES S. ANG-ELL, V., V., 10755 FALLS, NJ, BALTIMO 31. Date filed (Month, Day, Year) 32. Registar's Signature	oke mo	21093	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 1 2005 Segretar's Signature			